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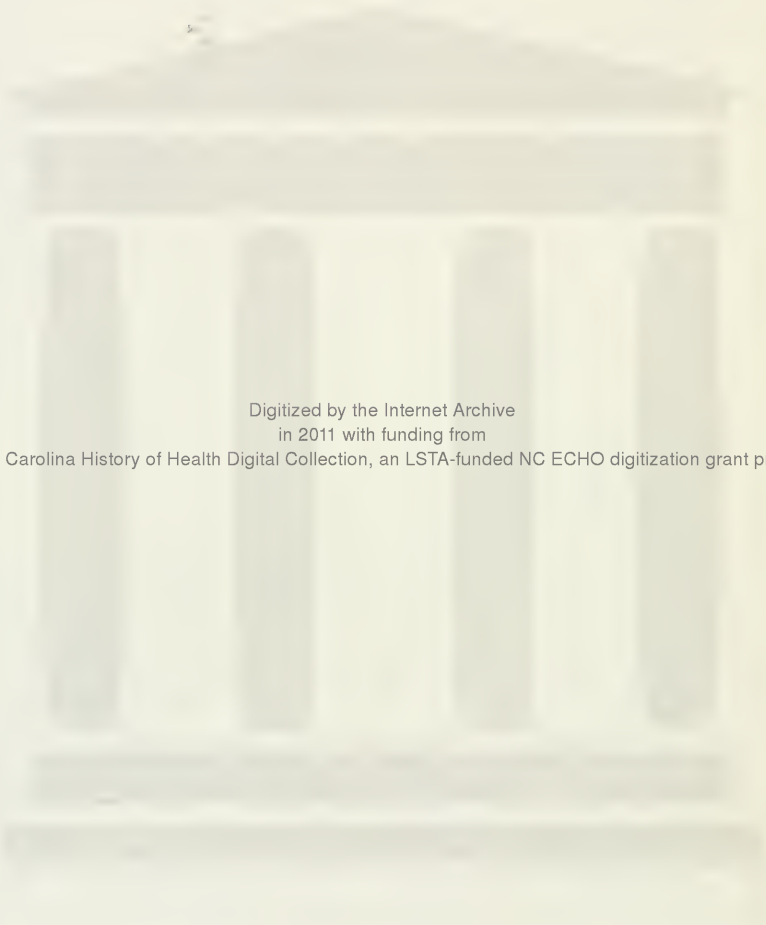

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Special: Legislative Issue

See NC General Assembly on page 9. See also President's Remarks on page 5.

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PRESIDENT'S REMARKS

Lots of new things have been getting underway lately, such as a new year, a new president, a new Congress, and a new General Assembly in NC. Some of these new happenings may have impressed you, others may have seemed so routine that little or no impact was felt. However, with each of these events, a change has occurred and change will continue to occur just like it always does. One can't get rid of it. Most certainly all of these changes will eventually have some impact on us, whether we choose to acknowledge it or not.

For the remaining portion of this month's column, I would like to focus on our new General Assembly which reconvened on January 11th. The changes our legislators have the potential to bring about during this Session could greatly impact the way we practice pharmacy in North Carolina, as well as affect the public we serve. How can we prepare ourselves for these potential changes?

First of all, please note the list of the NC General Assembly that appears in this issue of *The Carolina Journal of Pharmacy*. Retain this list for future reference; consider it one of your required pharmacy practice references. Find your state representative and state senator on this list; consider them one of your customers or patients whose records require your usual close attention.

Now, what will be ailing these customers during the current legislative Session? The list is endless, but we pharmacists should know that they will become infected with the following issues pertinent to pharmacy: a possible mail order program for all government employees (over 70,000!) across the state, dispensing by non-pharmacists, a possible triplicate prescription program for Schedule II drugs, and possible additional cuts in reimbursement by third party payers.

How can we help them fight off these afflictions? Well, we can start by educating them about these issues so that they can make an informed decision when the time comes to cast their ballot. We pharmacists have some strong medicine to offer, but it is up to us to see to it that our legislators get it. It is important for them to hear all sides of the story and how the outcome of their decision will affect not only us pharmacists, but also the health and welfare of the people in North Carolina. Our legislators really do want to know what their constituents think about these matters. After all, it is their constituents, like you, who keep them in office with the vote they need at election time.

You can dispense your medicine in a couple of ways, i.e., you can invite your legislators to one of your local society meetings and discuss these issues in an open forum with them as the Wake County Pharmaceutical Association did for their January meeting. You can also write to your legislators or volunteer to contact your legislators by indicating so on the "Legislature Contact Survey" recently sent to you by mail.

APhA, in conjunction with Glaxo, Inc., has published an excellent booklet entitled, "Make Your Voice Heard: Helpful Hints for Contacting Legislators." This booklet contains how-to tips for communicating effectively with your legislators and an easy-to-follow sample letter. To obtain one of these free booklets contact Mr. Al Mebane at: NCPhA, P.O. Box 151, Chapel Hill, NC 27514 or 1-800-852-7343 (in-state).

The NCPhA Legislative Committee is already doing their part. They began meeting with key legislators in early January and will continue to do so as the Session continues—possibly through August. NCPhA will keep you informed about legislative events as time progresses.

You can do your part by keeping abreast of these issues and helping to educate your legislative customers. They really need all the help they can get from their local pharmacist, you. Your medicine will not only help them do their job better, but it is the salvation of your profession and the people of North Carolina. **They need some of your medicine now.**

Al Lockamy, Jr.
President

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An Example "If It Ain't Broke, Fix It"

This is the second in a series of articles for professionals who manage and managers who lead professionals and those who are both.

The preceding article talked about stories and metaphors as powerful ways of leading an organization. We have to recognize that there are bad metaphors and stories as well as good ones. This has not been lost on our social conscience. We are not a homogenous society. We have not one work ethic, but many work ethics among us. Which one is right?

Curtis P. McLaughlin

Negative and Positive Examples

One of my favorite negative examples was given to me by a man from Sri Lanka with whom I often work. I was commenting on the negative, even destructive, criticism that I so often encounter among academics from his subcontinent. He said, "Yes, we have an old story. It seemed that some rebels captured three groups of tourists, one group from Germany, one from England, and one from Sri Lanka. To hold them they separated the three nationalities and put them in three different elephant traps, deep pits. Over top of the Germans they put a machine gunner. As soon as the first German started to climb out, the machine gunner fired just above his head and no one else tried to climb out. Over the English they put a philosopher. As soon as they started to climb out, he reasoned with them and convinced them to give up trying. But over the Sri Lankans they put no one. They knew that as soon as one started to climb out, the others would pull him down." That joke illustrates the power of a story, if only to stereotype people. But sometimes we do ourselves in in more subtle ways.

Philip Cosby's "Quality Is Free" is a successful positive example. Ten years ago management professors were teaching that management should select the optimal level of service for our products (the consumer can read that as disservice), trading off inspection costs versus quality. We paid only passing attention to statistical quality control. The Japanese embraced the worker-based statistical quality control that their American gurus taught them. But they didn't have to read **Quality Is Free.** To them errors are offensive and worth full effort to avoid. Their Confucian society gave them that value and its more appropriate one. In our Western heritage we needed a metaphor to counter their existing cultural value.

Useful metaphors can disappear. We seldom hear about the Hare and the Tortoise past kindergarten. We hear about going for the long ball and winning it big. Yet in today's world the American Hare drinks borrowed champagne and 10,000 foreign Tortoises own the toll gates.

Senior Executives' Error

I have heard many senior executives use old saw, "IF IT AIN'T BROKE, DON'T FIX IT." We as leaders have to watch the metaphors we use very carefully. As we try to compete more effectively in world economy, we have to change our behaviors. Our democratic system, fortunately, precludes large scale behavior modification, so we have to change our thinking first. Metaphors and analogies are very, very powerful methods of modifying thinking and behavior in organizations.

The notion that we shouldn't try to fix something that is not yet broken is a concept from the good old days of unlimited opportunities for growth and expansion, when executives had merely to pick among the plums. It may also be a self-aggrandizing idea, allowing the big boss to think "I have so much going on and everybody brings their problems to me and I'm so good at generating new ideas, so I've got to decide what is to be improved (by me, of course) and let the rest rock along." It ignores the fact that things that are not broken may be breaking. It fails to empower the workers to think about better ways to do things. It reduces the motivation for every worker to exercise that vaunted ingenuity exercised by relatively untutored Americans like Henry Ford,

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IF IT AIN'T BROKE

Continued from page 7

the Wright brothers and Eli Whitney, what used to be called Yankee ingenuity.

When the factory runs smoothly (ain't broke), the Japanese manager withdraws more inventory to unearth new problems. New problems mean new challenges, new opportunities, the things that pro-active managers think of as fun. It is a natural human response — one America seems to have lost sight of in the 60's. We are losing out to Japan because, despite our much larger population, Japan has many more active problem-solvers working more intensely. Furthermore, regardless of educational level, the more one works at problem solving the better one gets.

We can find lots of other questionable metaphors too like "going for the long ball." The Minnesota Twins went for the long ball in the 1987 World Series. In the last game in St. Louis the Cardinal runners apparently reduced the Twins infielders to Little Leaguer status. Then back to Minneapolis. But lo and behold, look what happened in the final game. The lumbering Twins began to run. First one man out at the plate, then another; one the victim of the umpire, not the throw. Then a third and a hurried Cardinal throw went wild. The Twins won. Luck of the Irish, Mr. Kelly? Don't know. I'd like to think he found a better way.

Leadership means helping people make sense of their world and helping them decide what to do and do best in their individual areas of influence. This is especially important in the back room operations that seem remote from the ultimate client. I suspect that it would be more important in hospital pharmacies where the people have less feedback from direct patient contact than their retail counterparts. If you are in this field, ask yourself what messages you hear and are sending.

Review Your Stories

Think about the significant metaphors you use and perhaps change a few. Psychologists often ask clients to write their own epitaph. It is a way to get them to think about the metaphors that guide them internally. Consultants on corporate culture often ask the organizations to identify its heroes and heroines and tell the stories associated with them. It is amazing how much those stories tell about the organization.

Perhaps a good place for you to start would be to dump the phrase, "If it ain't broke, don't fix it." Contrast that with the alternative view, more representative of the Germans and Japanese — "There has got to be a better way." You might even ask yourself, "Can I substitute 'There's got to be a better way.' Instead?" Then everyone is looking for that better way and a few might even find it. A few such payoffs every week and the whole organization moves ahead. Think about the power of thousands of employees generating small but low-cost improvements day-in and day-out. The impact can be awesome.

It will be well worth it. Just to motivate you we will tell a futuristic story.

> Raleigh, NC, Dec. 7, 2084 — "So I say, if it ain't broke, don't fix it." Immediately an electronic Groucho Marx appeared on that CEO's wall communicator. "You have just said the bad magic word, Madam. You have just won thirty lashes with a wet noodle and lost your ecstasy pills for the third and fourth days of your vacation."
>
> "Metaphor Control-Offense 2105-D" appeared at the lower left of the screen.

CURTIS P. MCLAUGHLIN is a Professor of Business Administration for the School of Business and Professor of Health Policy and Administration in the School of Public Health at the University of North Carolina at Chapel Hill. McLaughlin received his masters and doctorate degrees in Business Administration from Harvard Business School. He has written numerous management articles for a variety of publications, including Harvard Business Review, and has consulted for domestic and international corporations. Some of his professional interests include the production of professional services in research, engineering, medicine, public health and education; management of not-for-profit organizations; and productivity improvement.

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MARC BASNIGHT* (D-Dare)
Box 1025
Manteo, NC 27954

2nd District - Bertie (part), Edgecombe (part), Gates (part), Halifax (part), Hertford, Martin (part), Northampton and Warren (part). One Senator.
FRANK W. BALLANCE, JR. (D-Warren)
PO Box 358
Warrenton, NC 27589

3rd District - Carteret, Craven and Pamlico. One Senator.
BILL BARKER* (D-Pamlico)
PO Box 52
Oriental, NC 28571

4th District - Onslow. One Senator.
A.D. GUY* (D-Onslow)
306 Woodland Dr.
Jacksonville, NC 28540

5th District - Duplin, Jones, Lenoir and Pender (part). One Senator.
WENDELL H. MURPHY (Duplin)
PO Box 280
Rose Hill, NC 28458

6th District - Edgecombe (part), Martin (part), Pitt (part) and Wilson (part). One Senator.
R.L. "BOB" MARTIN* (D-Pitt)
PO Box 387
Bethel, NC 27812

7th District - New Hanover and Pender (part). One Senator.
FRANK BLOCK* (D-New Hanover)
Route 3, Box 303-G
Wilmington, NC 28403

8th District - Greene and Wayne. One Senator.
HENSON P. BARNES* (D-Wayne)
707 Park Ave.
Goldsboro, NC 27530

9th District - Beaufort (part), Martin (part) and Pitt (part). One Senator.
TOM TAFT* (D-Pitt)
611 Queen Anne Rd.
Greenville, NC 27858

10th District - Edgecombe (part), Halifax (part), Nash, Warren (part) and Wilson (part). One Senator.
JAMES E. EZZELL, JR.* (Nash)
3405 Winstead Rd.
Rocky Mount, NC 27804

11th District - Franklin, Vance and Wake (part). One Senator.
JAMES D. SPEED* (D-Franklin)
Route 6
Louisburg, NC 27549

12th District - Cumberland (part). Two Senators.
LURA S. TALLY* (D-Cumberland)
3100 Tallywood Dr.
Fayetteville, NC 28303

JOE B. RAYNOR (D-Cumberland)
2108 Morganton Rd.
Fayetteville, NC 28305

13th District - Durham, Granville, Orange (part) and Person. Two Senators.
RALPH A. HUNT* (D-Durham)
1005 Crete St.
Durham, NC 27707

KENNETH C. ROYALL, JR.* (D-Durham)
122 Long Shadow Pl.
Durham, NC 27713

14th District - Harnett, Lee, and Wake (part). Three Senators.
WILLIAM W. "BILL" STATON* (D-Lee)
636 Palmer Dr.
Sanford, NC 27330

JOSEPH E. "JOE" JOHNSON* (D-Wake)
1011 Harvey St.
Raleigh, NC 27608

J.K. SHERRON* (D-Wake)
3329 Julian Dr.
Raleigh, NC 27604

15th District - Johnston and Sampson. One Senator.
N. LEO DAUGHTRY (R-Johnston)
208 N. Second St.
Smithfield, NC 27577

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N.C. GENERAL ASSEMBLY

Continued from page 9

16th District - Chatham, Moore, Orange part) and Randolph. Two Senators.
WANDA H. HUNT* (D-Moore)
PO Box 1335
Pinehurst, NC 28374
RUSSELL G. WALKER*[1] (D-Randolph)
1004 Westmont Dr.
Asheboro, NC 27203

[1]A recount has been granted to both Republican nominees and certification is being withheld.

17th District - Anson, Montgomery, Richmond, Scotland, Stanly and Union. Two Senators.
J. RICHARD CONDER* (D-Richmond)
1401 Carolina Dr.
Rockingham, NC 28379
AARON W. PLYLER* (D-Union)
2170 Concord Ave.
Monroe, NC 28110

18th District - Bladen, Brunswick, Columbus and Cumberland (part). One Senator.
R.C. SOLES, JR.* (D-Columbia)
PO Box 6
Tabor City, NC 28463

19th District - Forsyth (part) and Guilford (part). One Senator.
ROBERT G. "BOB" SHAW* (R-Guilford)
4901-E Tower Rd.
Greensboro, NC 27410

20th District - Forsyth (part). Two Senators.
TED KAPLAN*
1001 Dalton
Lewisville, NC 27023
MARVIN WARD*
641 Yorkshire Rd.
Winston-Salem, NC 27106

21st District - Alamance and Caswell. One Senator.
GEORGE DANIEL* (D-Caswell)
PO Box 179-S
Semora, NC 27343

22nd District - Cabarrus and Mecklenburg (part). One Senator.
JAMES "JIM" C. JOHNSON, JR.* (R-Cabarrus)
29 Church St., N
Concord, NC 28025

23rd District - Davidson, Davie and Rowan. Two Senators.
BETSY L. COCHRANE (R-Davie)
Box 517, Burmuda Run
Advance, NC 27006
PAUL S. SMITH* (R-Rowan)
114 N. Milford Dr.
Salisbury, NC 28144

24th District - Alleghany, Ashe, Rockingham, Stokes, Surry and Watauga. Two Senators.
A.P. "SANDY" SANDS III* (D-Rockingham)
908 Oakcrest Dr.
Reidsville, NC 27320
W.D. "BILL" GOLDSTON JR.* (D-Rockingham)
PO Box 307
Eden, NC 27288

25th District - Cleveland, Gaston, Lincoln and Rutherford. Three Senators.
OLLIE HARRIS* (D-Cleveland)
PO Box 639
Kings Mountain, NC 28086
HELEN RHYNE MARVIN* (D-Gaston)
119 Ridge Lane
Gastonia, NC 28054
MARSHALL A. RAUCH* (D-Gaston)
1121 Scotch Dr.
Gastonia, NC 28054

26th District - Aleander, Catawba, Iredell and Yadkin. Two Senators.
AUSTIN M. ALLRAN* (R-Catawba)
515 6th St. NW
Hickory, NC 28601
HOWARD BRYAN* (R-Iredell)
1420 Mount Vernon Ave.
Statesville, NC 28677

27th District - Avery, Burke, Caldwell, Mitchell and Wilkes. Two Senators.
DONALD R. KINCAID
PO Box 988
Lenoir, NC 28645
DAN R. SIMPSON
PO Drawer 1329
Morganton, NC 28655

28th District - Buncombe, McDowell, Madison and Yancey. Two Senators.
ROBERT S. SWAIN* (D-Buncombe)
342 Gashes Creek Rd.
Asheville, NC 28803
DENNIS J. WINNER* (D-Buncombe)
81-B Central Ave.
Asheville, NC 28801

29th District - Cherokee, Clay, Graham, Haywood, Henderson, Jackson, Macon, Polk, Swain and Transylvania. Two Senators.
ROBERT C. "BOB" CARPENTER (R-Macon)
180 Georgia Rd.

Franklin, NC 28734

C.W. HARDIN[1] (R-Haywood)
67 Rhoda St.
Canton, NC 28716

[1]A recount has been granted one of the Democratic nominees and certification is being withheld.

30th District - Hoke and Robeson. One Senator.
DAVID R. PARNELL* (D-Robeson)
PO Box 190
Parkton, NC 28371

31st District - Guilford (part). One Senator.
WILLIAM N. "BILL" MARTIN*
PO Box 21325
Greensboro, NC 27420

32nd District - Guilford (part). One Senator.
RICHARD CHALK
427 Wright St.
High Point, NC 27260

33rd District - Mecklenburg (part). One Senator.
JAMES F. "JIM" RICHARDSON*
1739 Northbrook Dr.
Charlotte, NC 28216

34th District - Mecklenburg (part). One Senator.
T.L. "FOUNTAIN" ODOM
15131 Birling Ct.
Charlotte, NC 28217

35th District - Mecklenburg (part). One Senator.
LAURENCE A. "LARRY" COBB*
3022 Sharon Rd.
Charlotte, NC 28211

HOUSE OF REPRESENTATIVES

(* Indicates INCUMBENT)
(part = part of county)

1st District - Camden, Chowan, Currituck, Dare, Gates (part), Pasquotank, Perquimans, Tyrell and Washington. Two Representatives.
R.M. "PETE" THOMPSON (D-Chowan)
19 Queen Anne Dr.
Edenton, NC 27932

VERNON G. JAMES* (D-Pasquotank)
Route 4, Box 251
Elizabeth City, NC 27909

2nd District - Beaufort, Hyde and Washington (part). One Representative.
HOWARD B. CHAPIN* (D-Beaufort)
212 Smaw Rd.
Washington, NC 27889

3rd District - Craven, Lenoir and Pamlico. Three Representatives.
GERALD ANDERSON* (D-Craven)
2305 Brices Creek Rd.
New Bern, NC 28560

BEVERLY M. PERDUE* (D-Craven)
211 Wilson Point Rd.
New Bern, NC 28560

DANIEL T. LILLEY* (D-Lenoir)
1805 Sedgefield Dr.
Kinston, NC 28501

4th District - Carteret and Onslow. Three Representatives.
BRUCE ETHERIDGE* (D-Carteret)
115 Ann St.
Beaufort, NC 28516

W.D. "BILLY" MILLS (D-Onslow)
12 Belgrade-Swansboro Rd.
Maysville, NC 28555

ROBERT GRADY* (R-Onslow)
107 Jean Circle
Jacksonville, NC 28540

5th District - Bertie (part), Gates (part), Hertford (part) and Northampton. One Representative.
HOWARD J. HUNTER, JR. (D-Hertford)
PO Box 506
Murfreesboro, NC 27855

6th District - Bertie (part), Hertford (part), Martin (part) and Pitt (part). One Representative.
GENE ROGERS* (D-Martin)
908 Woodlawn Dr.
Williamston, NC 27892

7th District - Halifax (part), Martin (part) and Warren (part). One Representative.
THOMAS C. HARDAWAY* (D-Halifax)
207 McDaniel St.
Enfield, NC 27823

8th District - Edgecombe (part) and Nash (part). One Representative.
J.L. "JOE" MAVRETIC* (D-Edgecombe)
PO Box 100
Crisp, NC 27852

9th District - Greene and Pitt (part). Two Representatives.
ED WARREN* (D-Pitt)
227 Country Club Rd.
Greenville, NC 27834

WALTER B. JONES, JR.* (D-Pitt)
302 Hillcrest Dr.
Farmville, NC 27828

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N.C. GENERAL ASSEMBLY

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10th District - Duplin and Jones. One Representative.
CHARLES W. "CHARLIE" ALBERTSON (D-Duplin)
Route 2, Box 141-E
Beulaville, NC 28518

11th District - Wayne. Two Representatives.
JOHN KERR* (D-Wayne)
232 Ridgewood Dr.
Goldsboro, NC 27530

JOHN TART*
Route 1, Box 125-A
Goldsboro, NC 27530

12th District - Bladen, Pender (part) and Sampson. Two Representatives.
ED NYE* (D-Bladen)
PO Box 8
Elizabethtown, NC 28337

ED BOWEN* (D-Sampson)
Route 1, Box 289
Harrells, NC 28444

13th District - New Hanover (part). Two Representatives.
ALEX M. HALL* (D-New Hanover)
2715 Columbia Ave.
Wilmington, NC 28403

HARRY E. PAYNE, JR.* (D-New Hanover)
PO Box 1147
Wilmington, NC 28424

14th District - Brunswick, New Hanover (part) and Pender (part). One Representative.
E. DAVID REDWINE* (D-Brunswick)
58 Craven St.
Ocean Isle Beach, NC 28459

15th District - Columbus. One Representative.
LEO MERCER (D-Columbus)
115 Miller St.
Chadbourn, NC 28431

16th District - Hoke, Robeson and Scotland (part). Three Representatives.
DANIEL H. DeVANE* (D-Hoke)
136 Pinewood Circle
Raeford, NC 28376

JOHN C. "PETE" HASTY* (D-Robeson)
PO Box 338
Maxton, NC 28364

SIDNEY A. LOCKS* (D-Robeson)
PO Box 290
Lumberton, NC 28358

17th District - Cumberland (part). Two Representatives.
C.R. EDWARDS* (D-Cumberland)
1502 Boros Dr.
Fayetteville, NC 28303

NICK JERALDS* (D-Cumberland)
319 Jasper St.
Fayetteville, NC 28301

18th District - Cumberland (part). Three Representatives.
R.D. "DON" BEARD* (D-Cumberland)
2918 Skye Dr.
Fayetteville, NC 28303

ALEX WARNER* (D-Cumberland)
3610 Frierson St.
Hope Mills, NC 28348

JOHN W. "BILL" HURLEY (D-Cumberland)
313 Kirkwood Dr.
Fayetteville, NC 28303

19th District - Harnett and Lee. Two Representatives.
CLARENCE "C.P." STEWART (D-Harnett)
Route 3, Box 718
Lillington, NC 27546

DENNIS A. WICKER* (D-Lee)
1201 Burns Dr.
Sanford, NC 27330

20th District - Franklin and Johnston. Two Representatives.
BARNEY PAUL WOODARD* (D-Johnston)
PO Box 5
Princeton, NC 27569

BILLY J. CREECH (R-Johnston)
PO Box 148
Wilson's Mills, NC 27593

21st District - Wake (part). One Representative.
DANIEL "DAN" BLUE* (D-Wake)
2541 Albemarle Ave.
Raleigh, NC 27610

22nd District - Caswell, Granville, Halifax (part), Person, Vance and Warren (part). Three Representatives.
JAMES W. "JIM" CRAWFORD* (D-Granville)
509 College St.
Oxford, NC 27565

WILLIAM T. "BILLY" WATKINS* (D-Granville)
213 Thorndale Dr.
Oxford, NC 27565

JOHN T. CHURCH* (D-Vance)
420 Woodland Rd.
Henderson, NC 27536

23rd District - Durham. Three Representatives.
(NOTE: Districts 23, 68 and 69 are combined by court order.)

H.M. "MICKEY" MICHAUX, JR.* (D-Durham)
1722 Alfred St.
Durham, NC 27707

GEORGE W. MILLER, JR.* (D-Durham)
3826 Somerset Dr.
Durham, NC 27707

SHARON A. THOMPSON* (D-Durham)
PO Box 2164
Durham, NC 27702

24th District - Chatham (part) and Orange (part). Two Representatives.

ANNE BARNES* (D-Orange)
313 Severin St.
Chapel Hill, NC 27516

JOE HACKNEY* (D-Orange)
104 Carolina Forest
Chapel Hill, NC 27514

25th District - Alamance, Rockingham and Stokes (part). Four Representatives.

J. FRED BOWMAN* (D-Alamance)
814 H. Graham-Hopedale Rd.
Burlington, NC 27215

PEGGY WILSON (R-Rockingham)
214 W. Hunter St.
Madison, NC 27025

BERTHA "B" HOLT* (D-Alamance)
PO Box 1111
Burlington, NC 27215

R. SAMUEL "SAM" HUNT III* (D-Alamance)
1218 W. Davis St.
Burlington, NC 27215

26th District - Guilford (part) and Randolph (part). One Representative.

HERMAN C. GIST* (D-Guilford)
442 Gorrell St.
Greensboro, NC 27406

27th District - Guilford (part). Three Representatives.

ALBERT S. "AL" LINEBERRY* (D-Guilford)
26 Sturbridge Lane
Greensboro, NC 27408

JOANNE W. BOWIE (R-Guilford)
106 Nut Bush Dr., E.
Greensboro, NC 27410

FRANK J. "TRIP" SIZEMORE III* (R-Guilford)
711 N. Green St.
Greensboro, NC 27401

28th District - Guilford (part). Two Representatives.

STEVE ARNOLD (R-Guilford)
1610 Bridges Dr.
High Point, NC 27260

STEVE WOOD (R-Guilford)
1221-E N. Main St.
High Point, NC 27260

29th District - Forsyth (part) and Guilford (part). One Representative.

MICHAEL P. DECKER* (R-Forsyth)
6011 Bexhill Dr.
Walkertown, NC 27051

30th District - Chatham (part) and Randolph (part). One Representative.

ARLIE F. CULP (R-Randolph)
Route 2, Box 529
Ramseur, NC 27316

31st District - Moore. One Representative.

JAMES M. CRAVEN* (R-Moore)
PO Box 44
Pinebluff, NC 28373

32nd District - Richmond and Scotland (part). One Representative.

DONALD M. "DON" DAWKINS* (D-Richmond)
Route 3, Box 358
Rockingham, NC 28379

33rd District - Anson and Montgomery. One Representative.

PRYOR GIBSON (D-Anson)
Route 2, Box 382
Wadesboro, NC 28170

34th District - Cabarrus, Stanly and Union. Four Representatives.

COY C. PRIVETTE* (R-Cabarrus)
306 Cottage Dr.
Kannapolis, NC 28085

TIMOTHY N. TALLENT* (R-Cabarrus)
230 Palaside Dr., NE
Concord, NC 28025

BOBBY H. BARBEE, SR.* (R-Stanly)
PO Box 656
Locust, NC 28097

CLAYTON LOFLIN (R-Union)
1425 Medlin Rd.
Monroe, NC 28110

35th District - Rowan. Two Representatives.

CHARLOTTE A. GARDNER* (R-Rowan)

Continued on page 14

N.C. GENERAL ASSEMBLY

Continued from 13

1500 W. Colonial Dr.
Salisbury, NC 28144

BRADFORD V. "BRAD" LIGON* (R-Rowan)
Route 12, Box 460
Salisbury, NC 28144

36th District - Mecklenburg (part). One Representative.

LARRY DIGGS (R-Mecklenburg)
5001 Matthews-Mint Hill Rd.
Charlotte, NC 28212

37th District - Davidson, Davie and Iredell (part). Three Representatives.

CHARLES L. CROMER* (R-Davidson)
Route 4, Box 362
Thomasville, NC 27360

JOE H. HEGE, JR.* (R-Davidson)
1526 Greensboro St.
Lexington, NC 27292

JULIA C. HOWARD (R-Davie)
203 Magnolia Ave.
Mocksville, NC 27028

38th District - Randolph (part). One Representative.

HAROLD J. BRUBAKER* (R-Randolph)
Route 9, Box 375-A
Asheboro, NC 27203

39th District - Forsyth (part). Three Representatives.

ANN Q. DUNCAN* (R-Forsyth)
4237 Mashie Dr.
Pfafftown, NC 27040

THERESA H. ESPOSITO* (R-Forsyth)
207 Stanaford Rd.
Winston-Salem, NC 27104

FRANK E. RHODES* (R-Forsyth)
4701 Whitehaven Rd.
Winston-Salem, NC 27106

40th District - Alleghany, Ashe, Stokes (part), Surry and Watauga. Three Representatives.

DAVID H. DIAMONT* (D-Surry)
PO Box 784
Pilot Mountain, NC 27041

GENE WILSON (R-Watauga)
704 Queen St.
Boone, NC 28607

JUDY HUNT* (D-Watauga)
PO Box 1526
Blowing Rock, NC 28605

41st District - Alexander (part), Wilkes and Yadkin. Two Representatives.

JOHN W. BROWN* (R-Wilkes)
Route 2, Box 87
Elkin, NC 28621

GEORGE M. HOLMES* (R-Yadkin)
Route 1, Box 247
Hamptonville, NC 27020

42nd District - Iredell (part). One Representative.

LOIS S. WALKER* (R-Iredell)
611 Woods Dr.
Statesville, NC 28677

43rd District - Alexander (part), Catawba (part) and Iredell (part). One Representative.

C. ROBERT BRAWLEY* (R-Iredell)
Route 5, Box 96
Mooresville, NC 28115

44th District - Gaston and Lincoln. Four Representatives.

J. VERNON ABERNATHY, JR.* (R-Gaston)
306 Fallingbrook Dr.
Belmont, NC 28012

DORIS L. LAIL (R-Lincoln)
904 S. Aspen St.
Lincolnton, NC 28092

JOHNATHAN L. RHYNE, JR.* (R-Lincoln)
415 N. Cedar St.
Lincolnton, NC 28092

One seat to be filled

45th District - Burke (part) and Catawba (part). Two Representatives.

W. STINE ISENHOWER* (R-Catawba)
505 2nd Ave. NE
Conover, NC 28613

DORIS R. HUFFMAN* (R-Catawba)
Route 4, Box 81
Newton, NC 28658

46th District - Alexander (part), Avery, Burke (part), Caldwell, Mitchell and Watauga (part). Three Representatives.

DAVID T. FLAHERTY, JR. (R-Caldwell)
228 Pennton Ave.
Lenoir, NC 28645

GEORGE S. ROBINSON (R-Caldwell)
501 Norwood St.
Lenoir, NC 28645

CHARLES F. BUCHANAN* (R-Mitchell)
Route 1, Box 273
Green Mountain, NC 28740

47th District - Burke (part). One Representative.

RAY C. FLETCHER* (D-Burke)
PO Box 68
Valdese, NC 28690

48th District - Cleveland, Polk and Rutherford. Three Representatives.

JOHN J. "JACK" HUNT (D-Cleveland)
Box 227
Lattimore, NC 28089

JOHN WEATHERLY (R-Cleveland)
Route 3, Box 728
Kings Mountain, NC 28086

EDITH L. LUTZ* (D-Cleveland)
Route 3
Lawndale, NC 28090

49th District - McDowell and Yancey. One Representative.

ROBERT C. "BOB" HUNTER* (McDowell)
PO Box 1330
Marion, NC 28752

50th District - Henderson (part). One Representative.

LARRY T. JUSTUS* (R-Henderson)
PO Box 2396
Hendersonville, NC 28739

51st District - Buncombe, Henderson (part) and Transylvania. Four Representatives.

MARIE W. COLTON* (D-Buncombe)
392 Charlotte St.
Asheville, NC 28801

NARVEL J. "JIM" CRAWFORD (D-Buncombe)
15 Edgemont Rd.
Asheville, NC 28801

GORDON H. GREENWOOD* (D-Buncombe)
118 Portman Villa Rd.
Black Mountain, NC 28711

MARTIN L. NESBITT* (D-Buncombe)
6 Maple Ridge Lane
Asheville, NC 28806

52nd District - Graham (part), Haywood, Jackson, Madison and Swain. Two Representatives.

CHARLES M. BEALL* (D-Haywood)
Route 3, Box 322
Clyde, NC 28721

LISTON B. RAMSEY* (D-Madison)
PO Box 337
Marshall, NC 28753

53rd District - Cherokee, Clay, Graham (part) and Macon. One Representative.

MARTY KIMSEY (R-Macon)
Blaine Rd.
Franklin, NC 28734

54th District - Mecklenburg (part). One Representative.

JOHN B. McLAUGHLIN* (D-Mecklenburg)
PO Box 158
Newell, NC 28126

55th District - Mecklenburg (part). One Representative.

DAVID G. BALMER (R-Mecklenburg)
3800 Ayscough Rd.
Charlotte, NC 28211

56th District - Mecklenburg (part). One Representative.

JO GRAHAM FOSTER* (D-Mecklenburg)
1520 Maryland Ave.
Charlotte, NC 28209

57th District - Mecklenburg (part). One Representative

HARRY GRIMMER* (R-Mecklenburg)
4000 Highridge Rd.
Matthews, NC 28105

58th District - Mecklenburg (part). One Representative.

RUTH M. EASTERLING* (D-Mecklenburg)
811 Bromley Rd., Apt. 1
Charlotte, NC 28207

59th District - Mecklenburg (part). One Representative.

W. PETE CUNNINGHAM* (D-Mecklenburg)
3121 Valleywood Place
Charlotte, NC 28216

60th District - Mecklenburg (part). One Representative.

HOWARD C. BARNHILL* (D-Mecklenburg)
2400 Newland Rd.
Charlotte, NC 28216

61st District - Wake (part). One Representative.

JAMES "ART" POPE (R-Wake)
2405 Glenwood Ave.
Raleigh, NC

62nd District - Wake (part). One Representative.

PAUL "SKIP" STAM, JR. (R-Wake)
714 Hunter St.
Apex, NC 27502

63rd District - Wake (part). One Representative.

PEGGY STAMEY* (D-Wake)
6201 Arnold Rd.
Raleigh, NC 27607

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N.C. GENERAL ASSEMBLY

Continued from page 15

64th District - Wake (part). One Representative.
BETTY H. WISER* (D-Wake)
404 Dixie Trail
Raleigh, NC 27607

65th District - Wake (part). One Representative.
AARON E. FUSSELL* (D-Wake)
1201 Briar Patch Lane
Raleigh, NC 27615

66th District - Forsyth (part). One Representative.
ANNIE B. KENNEDY* (D-Forsyth)
3727 Spaulding Dr.
Winston-Salem, NC 27105

67th District - Forsyth (part). One Representative.
LOGAN BURKE* (D-Forsyth)
3410 Cumberland Rd.
Winston-Salem, NC 27105

68th District and 69th District - See 23rd District.

70th District - Edgecombe (part), Nash (part) and Wilson (part). One Representative.
MILTON F. "TOBY" FITCH* (D-Wilson)
516 S. Lodge St.
Wilson, NC 27893

71st District - Nash (part) and Wilson (part). One Representative.
LARRY E. ETHERIDGE* (R-Wilson)
3018 Fieldstream Dr.
Wilson, NC 27893

72nd District - Edgecombe (part) and Nash (part). One Representative.
ROY "COOP" COOPER, III* (D-Nash)
5016 Netherwood Rd.
Rocky Mount, NC 27804

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Pat G. Klein, Texas

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THE LOWER RESPIRATORY TRACT—

More vulnerable to infection in smokers and older adults

Experience counts

Ceclor® Pulvules® 250 mg
cefaclor

think of it first

For respiratory tract infections due to susceptible strains of indicated organisms.

See adjacent page for brief summary of prescribing information.

Lilly

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Ceclor®
cefaclor

Summary.
Consult the package literature for prescribing information.
Indication: Lower respiratory infections, including pneumonia, caused by *Streptococcus pneumoniae, Haemophilus influenzae,* and *Streptococcus pyogenes* (group A β-hemolytic streptococci)
Contraindication: Known allergy to cephalosporins
Warnings: CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS
Administer cautiously to allergic patients
Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.
Precautions:
• Discontinue Ceclor in the event of allergic reactions to it.
• Prolonged use may result in overgrowth of nonsusceptible organisms.
• Positive direct Coombs' tests have been reported during treatment with cephalosporins.
• Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
• Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
• Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.
Adverse Reactions: (percentage of patients)
Therapy-related adverse reactions are uncommon. Those reported include:
• Gastrointestinal (mostly diarrhea): 2.5%.
• Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
• Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, and serum-sickness-like reactions that have included erythema multiforme [rarely, Stevens-Johnson syndrome] and toxic epidermal necrolysis or the above skin manifestations accompanied by arthritis/arthralgia, and frequently, fever): 1.5%, usually subside within a few days after cessation of therapy. Serum-sickness-like reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.
• Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
• As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
• Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.
• Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%; and, rarely, thrombocytopenia.
Abnormalities in laboratory results of uncertain etiology:
• Slight elevations in hepatic enzymes.
• Transient fluctuations in leukocyte count (especially in infants and children).
• Abnormal urinalysis, elevations in BUN or serum creatinine.
• Positive direct Coombs' test.
• False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clinitest® tablets but not with Tes-Tape® (glucose enzymatic test strip, Lilly).
[042188LI]
Additional information available from Eli Lilly and Company, Indianapolis, Indiana 46285
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Carolina, Puerto Rico 00630

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CALENDAR OF EVENTS
1989

February: American Heart Month, National Children's Dental Health Month, National Safe Kids Week: 2/12-18

February 23—NCPhA Socioeconomic Seminar, Greensboro, NC

March 19-25—NATIONAL POISON PREVENTION WEEK

March 20—Board of Pharmacy Reciprocity Examination

March 21—Board of Pharmacy Meeting

April 8-13—APhA Annual Meeting, Anaheim, CA

April 18—Board of Pharmacy Meeting

May 15—Board of Pharmacy Reciprocity Examination

May 16—Board of Pharmacy Meeting

May 17-20—NCPhA Annual Convention, North Myrtle Beach, SC

May 21—NCPhA/NCSHP Management Seminar, North Myrtle Beach, SC*

June 4-8—ASHP Annual Meeting, Nashville, TN

June 20—Board of Pharmacy Meeting

June 26-27—Board of Pharmacy Licensure Examination

*Note: The NCPhA/NCSHP Seminar was previously scheduled on Wednesday, May 17, 1989. It has been changed to Sunday, May 21, 1989.

AROUND THE STATE

In response to the recent Readers' Survey conducted by The Carolina Journal of Pharmacy, this column, featuring news around the state, has been resurrected from the past. The NCPhA staff welcomes your comments and any contributions you wish to make to this column. Photos are also welcome. Send us your news!

Crime Reports

In the early hours of the morning on October 19, 1988, a Lincoln County man was caught leaving Sentry Drug Store in the Carolina Shopping City in Boger City, NC. The man was carrying the store's entire stock of Valium tablets when police arrested him. He entered the pharmacy by climbing onto trailers parked at the rear of the shopping center and onto the roof and then crawled in through the heating system. The burglar was charged with possession of burglary tools, breaking and entering, and larceny.

A trio of men suspected of spearheading a network of pharmacy break-ins in two states were caught after breaking into Eckerd Drug Store in Waynesville Plaza on October 11, 1988. The lock on the store's front door was pried open and the store was entered but nothing was taken. In addition to the Eckerd D.S. break-in, the men have also been charged with taking about $1,500 worth of drugs from Village Pharmacy in Waynesville.

Awards, Honors, Citations

Congratulations to Fred M. Eckel, professor and chairman of the Division of Pharmacy Practice at UNC who was recently honored by his high school. Fred was one of the first seven alumni to be inducted into the Abington High School Hall of Fame in Abington, Pa. He was recognized for his outstanding achievements in education.

Congratulations to Mike Morton, Vanceboro, for his "Memorable Moment in Pharmacy" as chronicled in the November 1988 issue of **American Druggist**. Mike and his wife, Kathryn, revived an elderly man in cardiac arrest in his pharmacy, using CPR they both knew.

Two researchers, **Dr. George H. Hitchings** and **Gertrude Elion**, at the Burroughs-Wellcome Company in Research Triangle Park were awarded the Nobel Prize in medicine from among 250 nominees. Hitchings lives in Carolina Meadows in Chatham County and Gertrude Elion resides in Chapel Hill. They were honored for their work at Burroughs-Wellcome where they developed Daraprim, Imuran, Zyloprim, and Zovirax. The two have been working together for 44 years. They will share a cash award of approximately $390,000 with a third corecipient, Sir James Black of Great Britain.

Suttle Drug Store of Shelby, **Moss Rexall Drugs** of Gastonia, and **Southcenter Pharmacy, Inc.** of Hendersonville were named among the nation's most outstanding independent pharmacies. The September 19, 1988 issue of *Drug Topics* magazine published a list of drugstores dubbed, "Independent Superstars of 1988." All three drug stores were named in the category for outstanding performance. **Sentry Drug Store** in Lincolnton was honored in the category for exceptional performance, **Buchanan's Drug** in Greensboro for handling a crisis and **Anderson Drug** in Elizabethtown and **Medical Center Pharmacy** in Hickory for overcoming competition.

Dr. Melvin Green of Southport, NC was awarded the 1988 NABP Distinguished Service Award on November 7, 1988 at NABP's Executive Officers Conference in Orlando, Florida. Dr. Green served as the Director of Educational Relations of the American Council on Pharmaceutical Education from 1952 to 1975. The award goes to individuals who, in the opinion of the executive committee, have made contributions to the goals and objectives of the National Association of Boards of Pharmacy without receiving appropriate public recognition.

In The News

Willie Rose took part in the annual Country Doctor Museum Day in his home town of Wilson. The 20-year-old museum was founded to preserve the heritage of the original country doctor. In a special presentation, Willie demonstrated the art of pill making using dried herbs.

Wayne Houston opened Houston's Pharmacy on October 1, 1988, in his hometown of Beulaville. Mayor Wilbur Hussey of Beulaville presided over the opening ceremonies.

The Weldon Business Bureau hosted a retirement dinner on October 12, 1988, for **J. Kelly Turner**, owner of Weldon Drug Company. Kelly and his wife, Peggy, were presented a plaque for thirty-eight years of dedicated service to the citizens of Weldon.

Loch Pharmaceuticals will build a new $20 million facility in Clayton. Executives expect the plant to be in operation in the Fall of 1989. A number of medical products including antibiotics, micro-nutrients and analgesics. State Representative Barney Paul Woodard attended groundbreaking ceremonies October 9, 1988.

Ray's Pharmacy in Dobson closed in September, 1988, after more than 20 years in business. Owner **Ray G. Hagwood** sold the pharmacy to Rite-Aid but he will continue to work at the store.

Brantley & Son, Inc. Pharmacy on Hillsborough Street in Raleigh is going out of business. The business, first started by John C. Brantley in 1910 is now operated by his son, John C. Brantley, Jr. The store is filled with pharmacy artifacts and memorabilia, including a marble and mahogany soda fountain dating back to 1905. Brantley has turned over copies of his customers' prescriptions to The Medicine Shoppe at 620 Glenwood Avenue.

Appointments

Van Hill King III of Wilmington has been elected to the board of directors of the UNC-CH School of Pharmacy Alumni Association. King has been employed as pharmacy manager at Seashore Drugs in Calabash since January 1988. At UNC he was president of the UNC Student Body and of Kappa Psi Faternity. As an alumni he has served several years as head class agent for Carolina Alumni Giving.

Evelyn P. Lloyd of Hillsborough achieved the distinction of being the first woman to be elected president of the NC State Board of Pharmacy in June 1988. Mrs. Lloyd earned her pharmacy degree from UNC-CH School of Pharmacy in 1965.

Priscilla Cuthbertson Brown, assistant manager of Revco D.S. in West Jefferson currently serves as vice chairman of the Board of Pharmaceutical Specialties (BPS). The BPS Board is composed of six pharmacist members and three non-pharmacist members, including one public representative and two health profession practitioners. In 1988, the BPS recognized and designated nutritional support pharmacy and pharmacotherapy as pharmacy specialties. Brown is a UNC-CH School of Pharmacy graduate.

James C. McAllister III, Director of Pharmacy at Duke Medical Center has been appointed to the Professional and Technical Advisory Committee for the Home Care Accreditation Program of the Joint Commission on Accreditation of Healthcare Organizations. The advisory committee, composed of persons from 16 health-related organizations, is charged with creating and revising home care standards in the U.S. McAllister was nominated by the American Society of Hospital Pharmacy to represent the organization in response to an invitation from the Joint Commission.

Mickey Watts of the Medical Center Pharmacy of Concord has been accepted as a member of the North Carolina Retail Merchants Association. This group's primary purpose is to represent the retailer's concerns to elected officials at the state and federal level.

Margaret and George McLarty III, built a true-to-scale replica of **McLarty's Drug Store**. The store is owned by their parents, Margaret and George McLarty, Jr. The children began the tedious project a year ago which is now on display at the drug store. Margaret is a UNC School of Pharmacy student.

Promotions

Louis Weaks has been promoted to Director of Pharmacy Services at Presbyterian Hospital in Charlotte. Before joining Presbyterian Hospital, Weaks spent 14 years as Pharmacy Director of Parkway Regional Medical Center in North Miami Beach, Florida.

K. Austin Burleson was promoted to Assistant Director of Pharmacy Services at Catawba Memorial Hospital. He is a 1976 graduate of the UNC-CH School of Pharmacy and has been employed at CMH for seven years.

Dale Hamrick, who has been with Kendall Drug Co. for the past 10 years, has been promoted to Vice President of Operations.

Other promotions announced by Gordon C. Hamrick, Chairman and CEO of Kendall Drug Co., wholesaler based in Shelby, NC, include:

Continued on page 22

AROUND THE STATE

Continued from page 21

Bobby McDaniel, who has been named Vice President of Sales. With a background of 38 years in drug wholesaling, McDaniel has been with Kendall for 11 years.

John Wortman, who was promoted to Vice President of Merchandising. A 14-year veteran at Kendall, Wortman will be responsible for inventory and product selection.

Weddings

Emily Byrd Hepler and Patrick Hugh Ahern were married at Convenant Presbyterian Church on October 29, 1988. The bride is a pharmacist with Stanley Drug Stores, Inc. in Charlotte and the groom is operations manager with Scott Drug Co. in Charlotte. Emily is a graduate of UNC School of Pharmacy. After a trip to the Caribbean the couple will live in Charlotte.

Michelle E. Lener and **Dennis M. Wiliams** were married October 1, 1988 at Olin T. Binkley Memorial Baptist Church. Both are UNC School of Pharmacy graduates. The bride is a clinical research scientist at Glaxo, Inc. and the bridegroom is a clinical assistant professor at the UNC-CH School of Pharmacy. They will live in Durham.

Kim Overcash and **Robert E. Fuller** were married at 7 p.m. December 10, 1988 at Bethesda Baptist Church. Robert is a UNC-CH School of Pharmacy graduate. He is owner of Crabtree Pharmacy in Durham.

Lori C. Tutterow wed **John R. Setzer** on October 15, 1988 at Maple Springs United Methodist Church in Winston-Salem. Both are UNC-CH School of Pharmacy graduates and both are employed as pharmacist-managers with Revco Drugs in Winston-Salem. Following a trip to St. Thomas, U.S. Virgin Islands the couple will continue to live in Winston-Salem.

Tammy A. Green of High Point and Gregory M. Gabard of Winston-Salem were married on Saturday, September 17, at Shady Grove United Methodist Church in Winston-Salem. Tammy is a 1986 graduate of the UNC School of Pharmacy and is employed at Revco D.S. in Winston-Salem. The couple will live in Winston-Salem.

Jennifer L. Smith and Christopher C. Bryant, both of Sanford, were married December 17 at St. Luke United Methodist Church. Jennifer attends the UNC School of Pharmacy. The couple will live in Raleigh.

Deaths

Roy P. (Pat) Rabb, II, of Marion, died Friday, March 25, 1988 at the age of 46. A 1964 graduate of the UNC School of Pharmacy, Rabb had worked in drug stores in Charlotte, Florida and with Eli Lilly and Company in Florida before retiring and returning to Marion in 1987.

Robert O. Cox died Tuesday, October 11, 1988 at his home in Wallburg. He was 92 years old. Born in Holly Grove, he operated a pharmacy in Winston-Salem from 1949 to 1968 when he retired. Mr. Cox was first licensed in 1917 in Michigan and was a former president of the Forsyth Drug Club.

Ray Creekmore, Reiglewood, died Saturday, November 26, 1988, after several years of declining health. He was 60 years old. A native of Columbus County, he was a veteran and operated pharmacies in Delco and Acme before opening his store in Reiglewood. He graduated from UNC in 1955. His son, Joseph, is also a pharmacist, receiving his B.S. in Pharmacy from UNC and a Ph.D. in Pharmacy from the University of Iowa.

Births

Cindy and **Doug Barrow** of Greenville announce the birth of their daughter Caroline Gray born November 26, 1988. Carolina has a brother Christopher, 6 years old and a sister Betsy, 9 years old.

Welcome, New Members!

Richard E. Stanford, Wisconsin

Kathryn W. McDonald, Spindale

Linda E. Baker, Carrboro

Susan S. Hoover, Charlotte

B. Mark Cloninger, Hickory

Anna M. Wells, Raleigh

Catherine A. Christianson, Andrews

YOUR PHARMACY ASSOCIATION WORKING FOR YOU

Drug Product Problem Reporting Program

Presented in cooperation with your state pharmaceutical association

Drug product quality is as important to us as it is to you. The **USP Drug Product Problem Reporting Program** is relying on your observations of poor product quality, therapeutic ineffectiveness, packaging and labeling problems, and possible product tampering to improve the quality of prescription and OTC drug products in the marketplace. The USP program is a private, non-governmental program designed to immediately inform participating product manufacturers and the FDA of potential health hazards and defective products based on the report *you* submit.

Reports may be submitted in writing using a USP report form or by calling USP toll free. The manufacturer or the FDA may contact you directly to discuss your concerns and USP will forward to you any information we may receive.

Your reports will be computerized and correlated with reports from other health professionals. This will allow for trend analysis of medical products on the market.

Your input is needed to help provide a complete picture of current trends for a more accurate evaluation of these products. Reports of problems experienced in your practice will help to provide practical input into the improvement of compendial standards in the USP/NF or drug information monographs in the USP DI.

We hope you will continue to support the USP Drug Product Problem Reporting Program...your input can make a difference!

USP Drug Product Problem Reporting Program
12601 Twinbrook Parkway, Rockville, Maryland 20852

Lockamy Is Appointed To APhA's Academy of Pharmacy Practice and Management

Al Lockamy, Jr., President of the North Carolina Pharmaceutical Association (NCPhA), has recently been appointed to the American Pharmaceutical Association's (APhA's) Academy of Pharmacy Practice and Management. He was appointed by the Academy's Executive Committee to assume the Member-At-Large position in the Section on Community and Ambulatory Practice vacated by L. N. Camp at Titusville, Florida. Lockamy will serve for one year, the remainder of Camp's two-year term.

When asked how he felt about the new appointment Lockamy said, "It is a great honor to be selected for the position from APhA's 37,000 members." NCPhA representatives are also happy about Lockamy's appointment as they are pleased to have one of their members represent North Carolina at the national level in APhA.

1925 Museum of History Pharmacy Exhibit Committee Progress Report submitted by W.J. Smith, Chairman

Groundbreaking for the new $25 million North Carolina Museum of History building took place this past summer in Raleigh. Presently, excavation for the underground parking lot to accommodate 500 cars is proceeding.

Pharmacy artifacts are being delivered to us from time to time for 1925 Pharmacy Exhibit planned for the new North Carolina Museum of History. Temporary protective storage has been made available to us in the Kerr Drug Warehouse, Raleigh, thanks to the generous cooperation of Committee Member, Banks Kerr.

Funding is also most sincerely welcome. You may want to plan ahead now to set aside funds in your 1989 Tax Deductible Account for the Museum Pharmacy Exhibit. Make check payable to NC Museum of History Associates and mail to me at: W.J. Smith, 908 Arrowhead Road, Chapel Hill, NC 27514. We appreciate your support and willingness to preserve the history of Pharmacy.

NCPhA Affiliates

Wayne County Pharmaceutical Society

Congratulations to the newly installed officers of the Wayne County Pharmaceutical Society:

President	Griff Howell
Vice President	Sherry Denning
Secretary	Johnnie Casey
Treasurer	Robert Worley

Wake County Pharmaceutical Association

Approximately 80 members gathered on January 10, 1989 for a Legislative Update Session. Gigi Federick, Secretary of the Association, and Grace Penny hosted the meeting at the NCSU Veterinary School in Raleigh where they are both employed as full time pharmacists at the campus animal hospital.

Legislators from the NC General Assembly were invited to join members for a dinner followed by an open forum on legislative issues pertinent to pharmacists. Dean Ron Maddox from Campbell University School of Pharmacy and Associate Dean George Cocolas from UNC School of Pharmacy were also present.

NC legislators in attendance were Rep. Aaron E. Fussell, D-Wake County, Rep. Paul "Skip" Stam, Jr., R-Wake County, Sen. Joseph "Joe" Johnson, D-Wake County.

President Benny Ridout led the forum discussion on mail order dispensing, dispensing by nonpharmacists, generic pharmaceuticals, and Catastrophic Health Insurance. Drs. Cocolas and Maddox followed with a brief report on their school's activities. A check for $500 was given to each school from the Association.

President Benny Ridout announced that the deadline for the Logo Contest has been extended. Members may submit a logo design for the Wake County Pharmaceutical Association which will be used for stationery, a banner, badges, etc. Winners will receive a complimentary dinner for two.

Charlotte Woman's Auxiliary

The Charlotte Woman's Pharmaceutical Auxiliary held its annual Christmas Party at the home of Mrs. Douglas Corwin (Dollie) on Monday, December 19, 1988. Members enjoyed a tour of her home, which was beautifully decorated throughout.

Punch and hors d'oeuvres were served to the members as they arrived. A delicious covered dish luncheon followed.

Christmas greetings were read from Mary Smith, who is now living in Bismarck, North Dakota. Gifts were then exchanged along with wishes for a Merry Christmas.

submitted by
Virginia Steele, Secretary

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IF YOU ARE INTERESTED IN REPRESENTING NCPHA AS A DELEGATE AT THE APHA 136th ANNUAL MEETING, APRIL 8–12, 1989 IN ANAHEIM, CALIFORNIA, PLEASE CALL MR. AL MEBANE AT NCPHA HEADQUARTERS: 1-800-852-7343 OR WRITE NCPHA, P.O. BOX 151, CHAPEL HILL, NC 27514

ANAHEIM
Pathway to Tomorrow
American Pharmaceutical Association
136th Annual Meeting and Exhibit
April 8–12, 1989

CONTINUING PHARMACEUTICAL EDUCATION (CPE) PROGRAMS

GUIDELINES: FOR COSPONSORSHIP OF CPE PROGRAMS

The University of North Carolina at Chapel Hill School of Pharmacy (including the Area Health Education Centers), Campbell University School of Pharmacy, North Carolina Pharmaceutical Association and North Carolina Society of Hospital Pharmacists will sponsor or cosponsor continuing pharmaceutical education programs according to established policies of each organization. If an organization wishes to **CO-SPONSOR** a CPE program with either School of Pharmacy, AHECs, NCPhA or NCSHP, the program **must** be jointly planned, developed and presented. Shared financial, administrative and quality control responsibilities must be agreed upon well in advance of the program. Generally, cosponsored programs should be planned at least 90 days before a program. The absolute minimum period is 30 days, except for programs to be offered in December of any year, which must be planned prior to November 1. A **CPE Program Approval Request Form** need **not** be completed for cosponsored programs.

GUIDELINES: FOR APPROVAL OF CPE PROGRAMS

APPROVAL of CPE programs which have been independently planned by any person or organization may be requested through the Continuing Pharmaceutical Education (CPE) Review Panel. This Panel is comprised of members representing the UNC-CH School of Pharmacy, Campbell University School of Pharmacy, AHECs, NCPhA and NCSHP. Only programs designed to improve pharmacists' ability to deliver pharmaceutical services should be submitted to the CPE Review Panel. Organizations seeking approval of independently planned programs must complete a **CPE Program Approval Request Form** as outlined below:

I. A **CPE Program Approval Request Form** (reverse side) must be completed and submitted to the Panel at least 30 days prior to the date of the program.

II. Within 10 days of receipt, the CPE Review Panel will notify the requesting organization of its action. Also, a sample program evaluation form, sample certificate of attendance and sample roster of participants will be sent to the organization.

III. Certification of attendance which is required by the N.C. Board of Pharmacy may be:
   A. Assumed as a responsibility of and prepared by the organization providing the CPE Program.

   B. Requested as a service of the CPE Review Panel.
      1. Within 2 weeks of the conclusion of a program the requesting organization must submit to the Review Panel:
         a. Roster of program participants with name, signature, mailing address, N.C. license #.
         b. Program evaluation forms.
         c. Payment @ $2.00 per certificate.
      2. The CPE Review Panel will prepare a CE Certificate which is acceptable to the N.C. Board of Pharmacy for each program participant. The certificates will be mailed in bulk to a contact individual of the requesting organization for distribution to participants.
      3. The CPE Review Panel will maintain records on all programs for 3 years.

Continuing Education Needs

What would you like to see offered in Continuing Education programs in your part of the state? What specific programs would best serve your professional educational needs? What are you NOT receiving in CE that would be helpful? Please write or call your requests to NCPhA in Chapel Hill. Toll-free 800-852-7343

DICKINSON'S PHARMACY
(by Jim Dickinson)

Safe dispensing speeds. I asked my neighborhood pharmacist about it, and he immediately became uncomfortable. "It can happen to anyone," he said charitably. Then he changed the subject to something safer — politics.

Probably the most uncomfortable topic of pharmaceutical conversation since Galen, "accurate dispensing" is under the national spotlight.

Modern pharmacists work under intense pressure. Stripped to its basics, the process of dispensing is demanding enough, without the added complexities of such recent pressures as new interactions, new dosage forms, new routes of administration, new colors and shapes, new generic sources, and totally new entities.

Compress these considerations into the same spread of working hours per day, with the faster decision-speeds demanded by pharmacy computers, and you have a kind of pharmacy practice that "old doc" on the corner could hardly have dreamed about in Norman Rockwell's time.

Yet even he was apt to be defensive when the subject of dispensing accuracy came up.

Now we have the subject under national scrutiny because of allegations about the mail-order drug industry, and about one company in particular.

That company, Medco Containment Services, Inc. (also known as National Rx Services), in defending itself against a prescription drug mix-up manslaughter charge in Idaho, has claimed a dispensing error rate of 0.0000006% (that's six zeros) of all the Rxs it has ever dispensed at its Las Vegas facility.

In contrast, it says that regular retail pharmacies have been measured as having a 5% error rate. The issue arises because of allegations that Medco places "enormous" pressure on its pharmacists, to the extent that dispensing speeds as high as 70-plus per hour have been claimed at the company. Medco denies this.

The Idaho court has been having a hard time dealing with this. As county prosecutor Craig Mosman charged in August, because of the company's habitual lying, who can believe what it says?

Medco, he told a local judge, has "made a systematic and deliberate practice of lying and covering up."

Mosman, a 29-year-old graduate of the local law school, withstood a blistering volley of accusations from four imported Medco attorneys in the case, which arises from the warfarin poisoning of 70-year-old Iris Hemmelman after she received a prednisone-labeled prescription from Medco's Las Vegas plant. The manslaughter charge, based on Medco's alleged "reckless disregard for human life" in its high-pressure, stressful dispensing of millions of Rxs a week, now goes to a jury trial in February.

James G. Dickinson

During investigations prior to bringing the charge, Mosman said Medco seemed unable to tell the truth. When asked about whether Medco had ever had a dispensing mix-up, or ever been investigated over one, the company's main attorney, Robert D. Marotta had said "No."

But when immediately confronted with the fact of the Senate subcommittee hearing a year ago at which mix-ups were described, and at which he testified, Marotta said he had "forgotten" about that.

In addition, Mosman said, Marotta had falsely informed a Nevada investigator that Mrs. Hemmelman had been prescribed warfarin for "an exotic blood disorder" and had complained about symptoms of that drug before Medco had shipped any prescription to her. Marotta lied so that the investigator would come to the conclusion that he did come to — "case closed" —Mosman alleged.

An FDA investigation, and others of Medco that the company wants to be considered by the court had been mischaracterized by Medco, Mosman said. FDA simply concluded that it had

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James G. Dickinson . . . Who is this mystery man? Mr. Dickinson's column, Dickinson's Pharmacy, has been running in our journal for the last two years. His column is syndicated and appears monthly in many state pharamaceutical journals across the country. Mr. Dickinson is also editor and publisher of Dickinson's FDA and Dickinson's PSAO industry newsletters. He has served as assistant executive director of the American Pharmaceutical Association and Washington bureau chief for Drug Topics. His home is in Morgantown, West Virginia.

CORRESPONDENCE COURSE
Advising Consumers on Vaporizers, Humidifiers, and OTC Inhalant Products

by Thomas A. Gossel, R.Ph., Ph.D.
Professor of Pharmacology and Toxicology
Ohio Northern University
Ada, Ohio

and

J. Richard Wuest, R.Ph., Pharm.D.
Professor of Clinical Pharmacy
University of Cincinnati
Cincinnati, Ohio

Goals

The goals of this lesson are to:

1. discuss the role of environmental humidity in maintaining maximal health;
2. explain basic actions of, and compare and contrast vaporizers and humidifiers; and
3. comment on OTC products intended for use with vaporizers.

Objectives

At the conclusion of this lesson, the successful participant will be able to:

1. explain differences between the actions, beneficial and otherwise, of vaporizers and humidifiers;
2. suggest how to correct vaporizer malfunctions by modifying water ion composition;
3. cite specific OTC inhalant products that are used in or along with vaporizers; and
4. provide pertinent consumer advice for proper use of vaporizers, humidifiers, and OTC inhalant products.

Maintaining proper humidification of environmental air is important for assuring normal functioning of the body's physiologic systems and promoting good health. Two areas that are dependent on a proper environmental humidity level are the skin and respiratory system.

When humidity is too low, skin dries and cracks, and loses its resistance to penetration by foreign chemicals and microbes. The body's first line of defense is, therefore, compromised. Likewise, when air is too dry, respiratory passages become irritated and inflamed, and symptoms such as coughing, hoarseness, and sore throat appear.

Pharmacies remain a major source of vaporizers and humidifiers for the public. Most consumers view the pharmacist as an authority on these appliances.

This lesson discusses the importance of maintaining proper environmental humidity. It compares and contrasts functions, operations, benefits and reported problems of vaporizers and humidifiers. It also evaluates OTC volatile inhalant products marked for use with vaporizers. Consumer advice concerning proper use is presented.

Importance of Proper Humidification

Absolute and Relative Humidity. Two terms that relate to moisture content of air are absolute and relative humidities. *Absolute* humidity expresses the amount of moisture present in a unit volume of air. *Relative* humidity measures the moisture content in air compared to the maximum quantity that would saturate it at any given temperature.

For example, when air contains half the moisture that it is capable of holding at a specific temperature, the relative humidity is 50 percent. Most individuals begin to feel uncomfortable when relative humidity decreases to below 25 percent. The pulmonary system functions best

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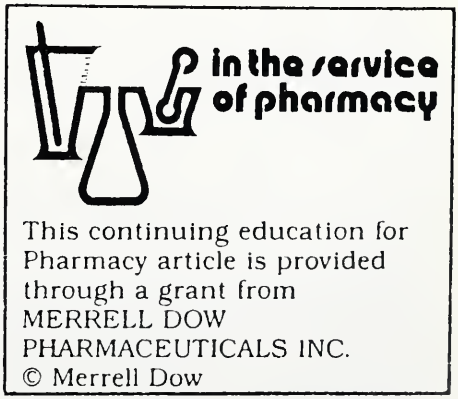
in the service of pharmacy
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CORRESPONDENCE COURSE

Continued from page 27

when relative humidity approximates 100 percent at body temperature.

Warm air can hold more moisture than cold air. In general, humidity is higher during the summer than fall and winter. During the winter months when the outside temperature is colder, air cannot contain the same quantity of moisture and the relative humidity drops.

Air inside a home that is artificially heated is likewise deficient in moisture content. The relative humidity of furnace-heated air can drop to below 10 percent. When this occurs, persons within the environment display symptoms of respiratory irritation, itching, and general discomfort.

So, relative humidity can also be described in terms of a "comfort index." The greater the value, the more comfortable an individual will be.

The body's humidification system consists of the nose, nasal passageways, the trachea and upper (proximal) sections of the bronchial tubes. Air entering the nose is heated by a rich supply of blood capillaries present in the nasal mucosal layer.

Even a cold nose on a winter day adds some warmth and moisture to inspired air. As this air descends to the warmer tracheal levels, more moisture and warmth are added. By the time air reaches the lungs, it is warmed close to body temperature, and its moisture content is approximately 99.5 percent saturated.

With expiration, the body rations its moisture. As expired air moves across progressively cooler respiratory passageways, it deposits moisture on these walls. This is one reason the nose may drip during periods of rapid breathing in cold weather. Its membranes, while warm in general, are still cooler than other respiratory passages. Therefore, it collects more fluid.

Cilia. Cilia are moving, hair-like protoplasmic protrusions located in the posterior portions of the nasal passageways. They move in a wave-like rhythm to propel foreign substances (e.g., infectious microorganisms associated with the common cold and influenza) upward and out of the respiratory system. They are able to do this because they are blanketed in a layer of mucus which normally is extremely rich in water content.

Cilia also add moisture to inspired air before it reaches the lungs. To achieve this, nasal mucosa must produce approximately one liter of fluid each day.

The respiratory mucus layer will dry and become overly viscous when relative humidity drops too low. Ciliary propulsion is hindered and mucus accumulates. This serves as an excellent culture medium for microbial growth. So, when the humidity is too low, an important normal defense mechanism of the respiratory system is lost. In fact, this area has now been converted to a breeding ground for microbes that may cause respiratory infections.

There is considerable evidence accumulated to date that proves that a person's incidence of upper respiratory infection increases when he is repeatedly exposed to low relative humidities. Twenty percent of all illnesses involving the nose and upper respiratory tract, sinus, and nasal pharynx are reportedly due to insufficient moisture in inhaled air.

The best means to assure that nasal mucus remains at its proper viscosity, and that cilia remain active is to increase humidification of air in the individual's environment. This can be readily and inexpensively achieved by using a vaporizer or humidifier.

Vaporizers

A vaporizer basically consists of a bowl to hold water, two electrodes which are surrounded by a plastic sheath open at the bottom, and a cover over the bowl that has an opening to emit steam (Figure 1). The electrodes and sheath are immersed in the water. There is usually a cup or depression in the cap at the point where the steam emerges. Volatile inhalant substances (Table 1) can be placed within it to be dispersed into the air along with steam.

To operate properly, vaporizers rely on minerals in tap water. In their ionized form, they

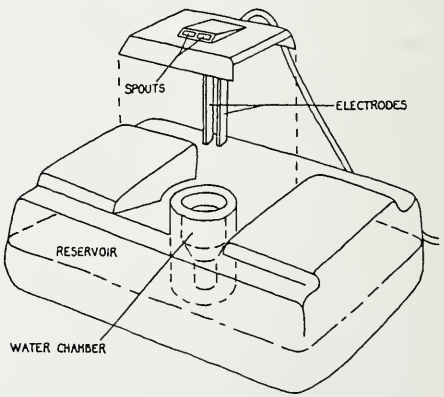

Figure 1. Vaporizer

complete an electric circuit between the electrodes. Water is heated and soon boils within the surrounding tube forming steam. The steam escapes into the atmosphere through the opening in the top of the unit. If the water level drops below the electrodes, the electrical circuit will be broken and steaming ceases.

As stated above, vaporizers are strongly dependent on the mineral content of water for activity. Two problems relating to mineral concentration may occur. In areas with excessive mineral content (hard water), malfunction is common. Steam flow will be erratic, tending to emit in spurts. The water may foam and even spill out of a filled bowl. When this occurs, tap water should be diluted with distilled water; the ratio should be adjusted appropriately.

In areas devoid of minerals, water is soft and steam production may be slow or absent. If the vaporizer does not begin producing steam within 10 to 15 minutes, a quarter-teaspoon of borax or baking soda should be added to the water to increase its electrical conductivity. Table salt should not be used since it promotes excessive corrosion of the electrodes.

Properly functioning, a vaporizer should begin to emit steam within 2 to 3 minutes. It should produce a steady flow in 15 to 30 minutes.

Mineral deposits can form on electrodes and decrease a vaporizer's efficacy. The unit should, therefore, be periodically dismantled and cleaned. The electrodes should be scraped free of deposits or soaked in a solution of vinegar for several hours. A commercially available OTC product (Table 1) for this purpose can also be used.

TABLE 1

Substances That May Be Used with a Vaporizer

Inhalants

Benzoin, Compound Tincture

Benzoin, Tincture

Camphor Spirit

VapoRub Ointment (Vicks)
(camphor, menthol, turpentine spirit, eucalyptus oil, cedar leaf oil, myristica oil, thymol)

VapoSteam Liquid, (Vicks)
(eucalyptus oil, camphor, menthol, tincture of benzoin)

Cleaner

Vap-O-Clean (Devilbiss)
(citric acid)

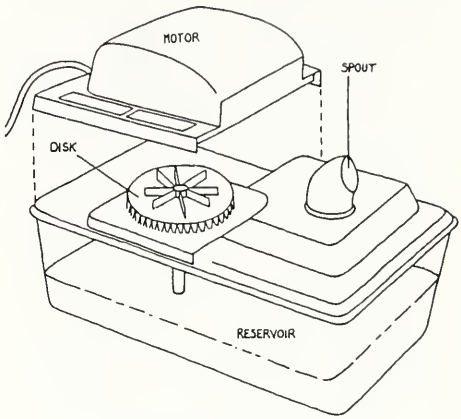

Figure 2. Humidifier

Humidifiers

A humidifier (Figure 2) differs from a vaporizer in that it produces a cool mist rather than hot steam. Humidifiers have moving parts.

Water is drawn by a motor-driven impeller through a chamber. It is thrust against a spinning disk that has a comb-like surface. This reduces the water particle size to tiny droplets which are discharged by the centrifugal force of the spinning disc into the atmosphere. The droplets readily evaporate, and thereby increase humidity in the room. Humidifiers do not use volatile inhalant medicinals. These substances are likely to ruin the unit.

Humidifiers are not affected by the hardness or softness of water used in them. In fact, humidifiers, but not vaporizers, can operate with totally distilled water. Humidifiers will also continue to run regardless of the presence or absence of water in the reservoir, and no harm will come to them if the reservoir runs dry. This means that most units must be turned off manually. Some of the more expensive models are equipped with humidostats which measure moisture in the air and shut the unit off automatically when the proper humidity has been reached.

Which is Better — Steam or Cool Mist Moisture?

Opinion is divided as to whether warm steam or cool mist moisture is more "healthy." Proponents of both systems claim definite advantages of one over the other. Neither side has yet gathered sufficient information to prove its argumentative position.

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CORRESPONDENCE COURSE

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It is the end result, increased environmental *moisture*, that is important. The means by which this is accomplished is irrelevant to personal health. Advantages and disadvantages of the appliances relate to other issues.

Steam Vaporizers. Those in favor of steamers argue that humidification of the room is achieved more rapidly with these appliances. Particle size of steam molecules is smaller than particles of cool moisture. However, if the unit is operated continuously, this should not be important.

They argue further that since the water is first boiled before added to the air, it is relative sterile. Most people agree that the units are less noisy than humidifiers and generally cost less to purchase. Vaporizers have an automatic shut-off feature, in that they stop working when the water is gone. Only the more expensive humidifiers have this feature.

Cool Mist Humidifiers. Proponents claim that humidifiers produce more rapid humidification since moisture is added to the air as soon as the unit is activated. There is no need to wait for the water to boil. But most vaporizers usually begin to emit steam within 2 to 3 minutes, so this argument has questionable merit.

Cool mist vapor does not increase the heat level within the room. It, therefore, reportedly causes less damage to walls and furniture.

Proponents of humidifiers frequently claim that vaporizers loosen wallpaper. But in consumer tests where this has been studied, it has not been shown to be a problem.

Since humidifiers demand less electricity to operate, their overall usage cost is less than that for vaporizers. However, the initial purchase price of humidifiers is higher.

Humidifiers are noisy to operate. The typical drone, hiss, or whirling sounds of a running humidifier may be bothersome to some individuals, but reassuring to others in that something is being done.

Volatile Inhalation Medications

The volatile substances shown in Table 1 are available for use with vaporizers. They should not be used with humidifiers.

It is questionable whether these substances impart significant therapeutic value to the patient. They do emit a pleasant "medicinal" smell to the air, and this "placebo" effect may be beneficial in comforting an anxious parent of a small child with congested, noisy, or labored breathing. In actuality, the child profits from the moisture; the parent benefits from the odor.

However, some consideration should be given to the fact that camphor/menthol-containing ointments rubbed on the chest have been proven to be safe and effective antitussives due to the inspired volatile ingredients. If the inhalant reaches the same concentration as that emitted from the applied ointment, the inhalant may be helpful in alleviating cough.

Consumer Advice

There is considerable evidence that moisture helps alleviate inflamed mucous membranes of the nasal pharynx and respiratory tract. Patients with colds, allergies or sinusitis will, therefore, benefit from increased atmospheric moisture. Their mucus-clogged nasal passageways will be easer to clear when a vaporizer or humidifier is used.

The appliance will also be beneficial in helping to lessen the incidence and severity of cough and sore throat, and, in general, will make breathing easier. Consumers who suffer frequent or recurring respiratory distress should be apprised that purchasing any device to increase air moisture content is undoubtedly a wise investment.

Consumers frequently call all vaporizer and humidifier units a "vaporizer." In fact, few consumers are reportedly able to distinguish correctly between them.

When advising consumers on their use, pharmacists should first make sure that the buyer knows which unit he wants and how to correctly operate it. Whether a consumer chooses a vaporizer or humidifier, the level of moisture in the air will be increased.

Consumers in one study were asked to comment on which safety features of vaporizers and humidifiers they considered to be most important. The most desired features included a locked cover, automatic shut-off switch, and all-night operating capacity.

A unit that has a minimum of one gallon (vaporizer) capacity or two gallon (humidifier) capacity water reservoir is best to recommend so that it will indeed provide the moisture necessary for all-night operation.

When in operation, it is best to place a vaporizer on the floor rather than on furniture. Direct forceful steam may ruin furniture and the unit may be more easily tipped over. If a vaporizer or humidifier must sit on furniture, a towel should be placed underneath it. The units collect moisture on their sides. Droplets of water fall from both steam and cool mist which may damage unprotected furniture.

Unless specifically directed by a physician, steam flow should not be directed toward the patient, but toward an open area so that air in the entire room may be uniformly moistened. Individuals should be warned not to insert finger into the water supply of an operating vaporizer to test its temperature. The electrical plug must always be pulled from the outlet before working on the unit.

Vaporizers and humidifiers should be guaranteed against defects. Units that do not meet minimum standards of Underwriter's Laboratories should be avoided. Modern safety features include a solid base so that the vaporizer will not tip even when inclined at a 30° angle, regardless of the quantity of water in the bowl. Water temperature should not exceed 130°F. It should have a locked cover to guard against spilling if the unit should accidentally tip.

Vaporizers and humidifiers should be thoroughly cleaned and dried after use. Water should not be allowed to stand in the reservoir if the unit is not in operation. Bacterial and fungal organisms may grow in it and be spread into the air when the unit is later activated. A condition known as *humidifier fever* may result in susceptible persons. Vaporizers are less likely to spread infection because microorganisms cannot survive in boiling water. But they can and do grow in the cooler parts of the plastic. If a vaporizer or humidifier is used only a few hours each day, fresh water should be added each time before operating the unit.

CORRESPONDENCE COURSE QUIZ
Vaporizers/Humidifiers

1. The device that is LEAST affected by hardness or softness of water placed in it is the:
   a. humidifier.
   b. vaporizer.
2. Which of the following environmental temperatures hold the greatest quantity of moisture?
   a. Cold
   b. Warm
3. The hair-like protoplasmic protrusions located in the posterior portion of the nasal passageways are called:
   a. pharynges.
   b. nodules.
   c. polyps.
   d. cilia.
4. Commercially available volatile substances are intended to be used in:
   a. humidifiers.
   b. vaporizers.
5. Relative humidity measures the moisture content of air compared to:
   a. a standard kept on file in Washington, D.C.
   b. the amount present in respiratory passages.
   c. the maximum quantity it can hold.
   d. the minimum quantity it can hold.
6. Which of the following environmental conditions is most associated with a higher incidence of respiratory infections?
   a. High relative humidity
   b. Low relative humidity
7. The device that has a motor and moving parts is a:
   a. humidifier.
   b. vaporizer.
8. The body's pulmonary system functions best when the relative humidity approximates:
   a. 25 percent.
   b. 50 percent.
   c. 75 percent.
   d. 100 percent.
9. As expired air moves across progressively cooler respiratory passages, it:
   a. deposits moisture on passageway walls.
   b. picks up and carries moisture with it.
10. The device that should be dismantled and cleaned from time to time is a:
    a. humidifier.
    b. vaporizer.

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- NCPhA will maintain a copy of your completed CPE tests and upon successful completion of each program, will issue a certificate for one (1) hour of board-approved CPE.
- If more than two questions are answered incorrectly, the test is failed. You will be given one opportunity to submit a second answer sheet.

Please circle correct answers

1. a b c d	4. a b c d	7. a b c d
2. a b c d	5. a b c d	8. a b c d
3. a b c d	6. a b c d	9. a b c d
		10. a b c d

Evaluation: Excellent Good Fair Poor

name

address

DICKINSON'S PHARMACY

Continued from page 26

no jurisdiction (not, as Medco claimed, that the company had done no wrong).

Further, a study by the University of Tennessee that Medco sought to have admitted as evidence of its dispensing accuracy was in fact only a public-opinion survey on mail-order pharmacy versus retail pharmacy and had nothing to do with Medco or the case.

At trial before a jury, Mosman intends to present evidence on what an accurate, safe dispensing speed should be.

He will seek to present unbiased witnesses who have studied this issue — which, because of its great sensitivity, is not one of the most-studied pharmacy issues there is.

One study he has scheduled for presentation is a 1983 *Drug Intelligence & Clinical Pharmacy* paper by Brock G. Guernsey et al of the University of Texas, indicating that there is a 90% chance of a pharmacist making one or more potentially serious dispensing errors per hour at the 30-prescription-per-hour rate that supposedly prevails at Medco's Las Vegas facility.

The study defined "potentially serious" as incorrect directions, incorrect drug, incorrect dosage information, incorrect drug strength, directions improperly changed, pharmacist neglected to clarify order, or absent directions. The study was based on an audit of 9,394 Rxs filled in 12 days at an unnamed high-volume hospital outpatient pharmacy.

The study found a direct, linear correlation between errors and dispensing speed per hour, and it observed that most dispensing errors simply "are never detected." The authors recommended a dispensing speed limit of 120 prescriptions per shift — or about 16 per hour.

Whether Medco is ultimately found innocent or guilty, a growing number of authorities believe the time is now at hand when a national standard needs to be established for a safe dispensing speed.

This feature is presented on a grant from G.D. Searle & Co., in the interests of promoting the open discussion of professional issues in pharmacy. G.D. Searle & Co. accepts no responsibility for the views expressed herein as they are those of the author and not necessarily those of G.D. Searle & Co.

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RETAIL POSITIONS OPEN

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PHARMACIST WANTED: We are seeking an ambitious, and professional career-minded individual for a pharmacist position in Greensboro, High Point and Winston-Salem, NC. We offer excellent salary, stock ownership, educational subsidy, extensive benefits, retirement plan, 401K tax plan, annual salary merit reviews. "Pure pharmacy setting". If interested call Lew Thompson at 1-800-233-7018 or send resume to: The Kroger Company, Attn: Personnel, P.O. Box 14002, Roanoke, VA 24038. EOE.

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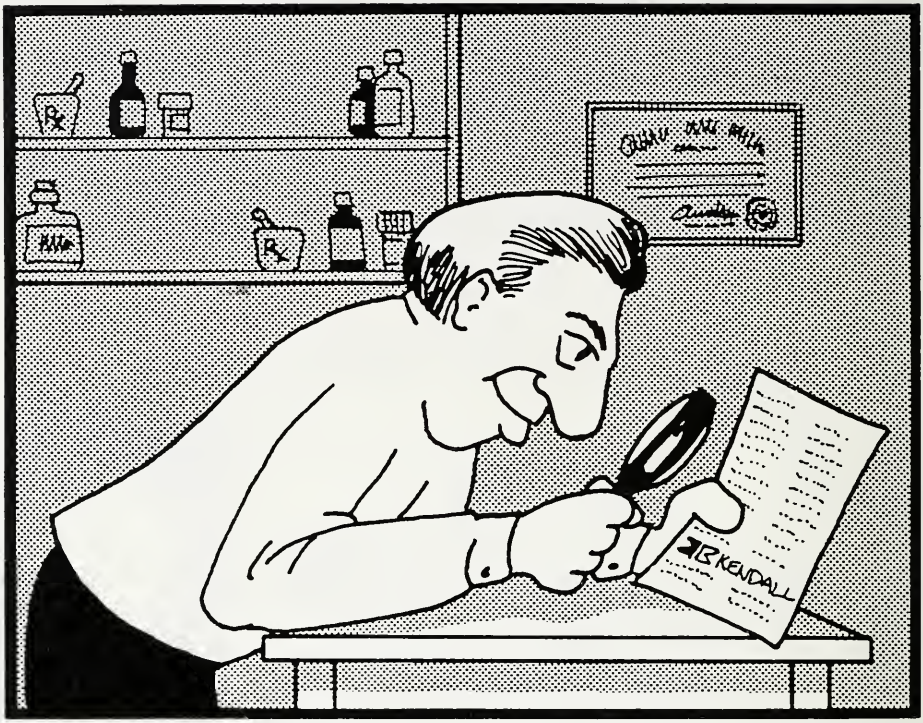

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Dear Non Member of NCPhA:

This year we are sending every North Carolina pharmacist a complimentary issue of NCPhA's monthly publication, *The Carolina Journal of Pharmacy*. This is a courtesy—in hopes that you will decide to join the North Carolina Pharmaceutical Association and support our endeavors.

Please take a look at us and note the following in this issue: our Annual Convention Program on page 7 and comments from our President regarding NCPhA membership benefits on page 5. Each month our journal features State Board of Pharmacy reports, news from local associations, a calendar of events, commentary from a nationally syndicated columnist, comments from the NCPhA president, classified advertising, news briefs about people in pharmacy in North Carolina, new members and continuing education home study courses.

I guess it's hard to argue that membership in NCPhA pays, particularly if your colleagues (NCPhA members) are willing to foot the bill for the legislative initiatives, governmental representations, and the other myriad benefits that accrue to all pharmacists because of the efforts of the Association. Of course, if your colleagues made the same decision as you, then the profession of pharmacy and the rewards that have been achieved and enjoyed by all pharmacists would dissipate. Why don't all pharmacists support their Association? It can't be because of the dues—they are only 21¢ a day—not even as much as a cup of coffee! How can you afford not to become a member? It is your profession—your livelihood.

We cordially invite you to join your fellow pharmacists by becoming a member of the Association. Your colleagues need your support to help preserve Pharmacy in North Carolina. Please complete the form below and send it in today (or call 800-852-7343). We'd like to see you at NCPhA's 109th Annual Convention, May 17-21, 1989 in North Myrtle Beach, South Carolina.

A.H. Mebane
Executive Director, NCPhA

Yes, I would like to join the North Carolina Pharmaceutical Association. Please send me an application.,

Name _____

Address _____

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PRESIDENT'S REMARKS

Many of you have already renewed your 1989 NCPhA membership, that is, approximately half of our 2500 members! For those of you who have not, don't wait any longer! Each additional reminder the Association sends to you adds up quickly in costly dollars. What is more, you don't want to miss out on the many services available to you through NCPhA, as well as the opportunity to network with professional colleagues.

Did you know that the following services and benefits are available to members, most of which are *free*!?

- *The Carolina Journal of Pharmacy*, the only state pharmaceutical journal in NC. In addition, a home study article is featured each month worth 1 CE hour — that's 12 CE hours per year!
- *The Tar Heel Digest*, a monthly bulletin of up-to-date information regarding professional rules, regulations and news briefs.
- *The Mortar and Pestle Gazette*, a monthly bulletin containing employment and business opportunities.
- Full time representation/lobbying in the NC legislature.
- The Institute of Pharmacy, NCPhA headquarters, with facilities (including a 100-seat auditorium) for any pharmacy oriented meeting.
- The Annual NCPhA Convention.
- Coordinated activities with various state and federal agencies and other health professions.
- An extensive library of educational films, booklets, and display materials.
- Involvement with national pharmaceutical associations.
- The Pharmacist Recovery Network (PRN), providing assistance for impaired pharmacists.
- High visibility projects, e.g., the annual NC Pharmacy Week.
- Major Medical, Professional Liability, Disability Income, Whole and Term Life Insurance, Income Replacement, and a Comprehensive Store Owners Package.
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- Opportunity for Involvement in your profession through NCPhA Committees: Community Pharmacy; Employer/Employer Relations; Ethics, Grievance & Practice; Mental Health; National Legislation; Pharmacy Museum; Public & Professional Relations; Public Health; Social & Economic Relations; State Legislation; Third Party; Nominating; Constitution & Bylaws; Continuing Education; Finance; Resolutions; PharmPAC.

What a deal for only $75.00!

I hope to see you at the 1989 NCPhA Beach Convention Vacation, May 17-21, at the North Myrtle Beach Hilton in sunny South Carolina! Besides the opportunity to obtain 15 hours of CE credit, many fun activities have also been planned. (See the Convention Program on page 7 of this issue.)

Bring the whole family along, too, to enjoy the beach, golf, tennis, the T.M.A. Dance featuring *THE EMBERS*, and a Luau by the pool featuring the Hawaiian entertainment group, *Lei Aloha's Polynesian Rainbow Revue*. The North Myrtle Beach Hilton is located right on the beach and the $92.00 a night rates for this oceanfront hotel are unbeatable!

Come join us in the sun!

Al Lockamy
President, NCPhA

North Myrtle Beach Hilton, South Carolina, site of the NCPhA Beach Convention Vacation, the 109th Annual Convention, May 17-21, 1989.

THE NORTH CAROLINA PHARMACEUTICAL ASSOCIATION BEACH CONVENTION VACATION

North Myrtle Beach Hilton, South Carolina
109th Annual Convention
May 17-21, 1989
Convention-in-Brief

Wednesday, May 17

3:00 p.m.-6:00 p.m.	Registration *Main Lobby*
6:00 p.m.	PRESIDENTS' RECEPTION honoring the Presidents of NCPhA, the Woman's Auxiliary & the Traveling Member's Auxiliary *Pool Terrace*
7:00 p.m.	*OPENING SESSION BANQUET — Master of Ceremonies, President Al Lockamy, Jr.; featured speaker, Robert H. Henry presenting, "Win With A.C.E.S., Attitude & Ambition, Commitment, Enthusiasm and Service" followed by Award presentations *Center Ballroom*

Thursday, May 18

7:00 a.m.	Woman's Auxiliary Beach Walk-A-Thon (Everyone is invited to participate.)
7:30 a.m.	Traveling Member's Auxiliary Breakfast *Staff Conference Room*
7:30 a.m.	V.I.P. Breakfast *West Ballroom*
8:00 a.m.-1:00 p.m.	Registration *Main Lobby*
9:00 a.m.	**1st NCPhA BUSINESS SESSION — President-Elect, Ralph H. Ashworth, presiding. Rite of the Roses conducted by Third Vice President, Mr. Robert W. Worley and Mrs. Robert W. Worley; President's Address; Schools of Pharmacy Reports; CE Program: "Legal Issues Associated With Expanded Roles For Pharmacists With Regard To Patient Services" presented by Walter Fitzgerald, J.D., Executive Director and General Counsel, American College of Apothecaries *East Ballroom*
10:30 a.m.	Woman's Auxiliary Brunch and Fashion Show by Myrtle Beach's *Victoria's Ragpatch.* **Sponsored by Glaxo, Inc.** *South Deck*
12:30 p.m.	Practitioner-Instructors' Luncheon *Parlours I-IV*
12:30 p.m.	Woman's Auxiliary Shopping Spree at Pawley's Island
1:00 p.m.	GOLF & TENNIS TOURNAMENTS — **Golf sponsored by Owens Brockway, Co-Chairmen, Junior Little & Mike Joyner; Carts by Burroughs Wellcome Co.; Tennis sponsored by Jefferson Pilot, Co-Chairmen, G.N. (Jerry) Brunson & Sam Stuart**
9:00 p.m.-midnight	T.M.A. Dance featuring *THE EMBERS*; cash bar. **Sponsored by the Traveling Member's Auxiliary** *Center Ballroom*

Friday, May 19

7:00 a.m.	*PharmPAC Breakfast (Everyone is welcome.) *Alfredo's*
8:00 a.m.-1:00 p.m.	Registration *Main Lobby*

Continued on page 9

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"Researching and developing an effective medicine costs, on average, $125 million.* It takes years of testing and retesting, analyzing and perfecting, before new medicines can be made available to medical professionals and patients who need them.

"As associate director of Clinical Development at Glaxo Inc., I'm part of that investment.

"Because there's such a large investment of time and money in all of our medicines, Glaxo Inc., like other research-oriented pharmaceutical manufacturers, is committed to making medicines of the highest quality and effectiveness. Glaxo works hard to provide prescription medicines that can help you feel better."

*Wiggins, Steven N. "The Cost of Developing a New Drug," Pharmaceutical Manufacturers Association, Washington, D.C., June 1987.

Glaxo

Medicines for Your Health

Glaxo Inc., Research Triangle Park, NC 27709

8:30 a.m.	Woman's Auxiliary Coffee *Hospitality Room 402*
9:00 a.m.	**2nd NCPhA BUSINESS SESSION — Second Vice President, J. Frank Burton, Jr., presiding. CE DAY, Program 1: Cholesterol Education Program by Kirk Ways, M.D., East Carolina School of Medicine, Department of Endocrinology. Program 2: "Managing Your Pharmacy's Financial Health" by Jean P. Gagnon, Ph.D., Director of Pharmacy Relations, Marion Laboratories *East Ballroom*
9:30 a.m.	Woman's Auxiliary Business Session *West Ballroom*
11:00 a.m.	Traveling Member's Auxiliary Business Session *Parlours I-IV*
12:00 p.m.	Woman's Auxiliary Luncheon featuring *The First Resort*, A Sweet Adelines Barbershop Quartet. **Sponsored by Burroughs Wellcome Co.** Installation of Officers will follow the luncheon. *Another World*
12:00 p.m-1:00 p.m.	Complimentary lunch for Exhibitors in *The Exhibit Hall*
1:00 p.m.-6:00 p.m.	EXHIBITORS FAIR AND LUNCHEON *The Exhibit Hall*
11:00 p.m.	ICE BOX RAID/DESSERT RECEPTION *Pool Terrace*

Saturday, May 20

7:30 a.m.	*1939 Class Reunion Breakfast *Parlours I-IV*
7:30 a.m.	*Christian Pharmacists' Breakfast *Another World*
8:00 a.m.-12:30 p.m.	Registration *Main Lobby*
9:00 a.m.	**3rd NCPhA BUSINESS SESSION — President Al Lockamy, Jr., presiding. Annual Salary Survey presented by Jan Phillips, Ph.D.; NCPhA Committee Reports; Nominations of NCPhA 1990-91 Officers; Executive Director's Report *East Ballroom*
12:30 p.m.	*RECOGNITION LUNCHEON Installation of Officers, Luncheon, 50-Plus Club Inductions and Awards *Center Ballroom*
2:30 p.m.-5:00 p.m.	Academy of Consulting Pharmacists — moderator, Charles Pulliam *Parlours I-IV*
7:00 p.m.	*A NIGHT IN THE ISLANDS featuring a Luau feast and the *Lei Aloha's Polynesian Rainbow Revue Pool Terrace & Deck*

Sunday, May 22

8:00 a.m.	Seminar Registration
9:00 a.m.-3:00 p.m.	SEMINAR: THE PHARMACIST'S ROLE & RESPONSIBILITY IN HEALTH PROMOTION AND DISEASE PREVENTION —Sponsored by NCPhA and NCSHP. Background information on cancer screening and substance abuse recognition and prevention and "how-to" programs for use in your community will be presented. Six contact hours of A.C.P.E. Continuing Education will be provided. Look for details of the seminar program in the mail.

**Reservations for these activities may be purchased through the NCPhA office.*
***All convention registrants are invited to NCPhA's Business Sessions.*

THE NORTH CAROLINA PHARMACEUTICAL ASSOCIATION BEACH CONVENTION VACATION

North Myrtle Beach Hilton, South Carolina
109th Annual Convention
May 17-21, 1989
Program

Wednesday, May 17

3:00 p.m.-6:00 p.m.	Registration *Main Lobby*
6:00 p.m.	PRESIDENTS' RECEPTION honoring the Presidents of NCPhA, the Woman's Auxiliary & the Traveling Member's Auxiliary *Pool Terrace*
7:00 p.m.	*OPENING SESSION BANQUET — Master of Ceremonies, President Al Lockamy, Jr. featured speaker, Robert H. Henry presenting, "Win With A.C.E.S., Attitude & Ambition, Commitment, Enthusiasm and Service" followed by Award presentations *Center Ballroom*

Thursday, May 18

7:00 a.m.	Woman's Auxiliary Beach Walk-A-Thon (Everyone is invited to participate.)
7:30 a.m.	V.I.P. Breakfast *West Ballroom*
8:00 a.m.-1:00 p.m.	Registration *Main Lobby*
9:00 a.m.	**1st NCPhA BUSINESS SESSION — President-Elect, Ralph H. Ashworth, presiding. Rite of the Roses conducted by Third Vice President, Mr. Robert W. Worley and Mrs. Robert W. Worley; President's Address; Schools of Pharmacy Reports; CE Program: "Legal Issues Associated With Expanded Roles For Pharmacists With Regard To Patient Services" presented by Walter Fitzgerald, J.D., Executive Director and General Counsel, American College of Apothecaries *East Ballroom*
12:30 p.m.	Practitioner-Instructors' Luncheon *Parlours I-IV*
1:00 p.m.	GOLF & TENNIS TOURNAMENTS — **Golf sponsored by Owens Brockway, Co-Chairmen, Junior Little & Mike Joyner; Carts by Burroughs Wellcome Co.; Tennis sponsored by Jefferson Pilot, Co-Chairmen, G.N. (Jerry) Brunson & Sam Stuart**
9:00 p.m.-midnight	T.M.A. Dance featuring *THE EMBERS*; cash bar. **Sponsored by the Traveling Member's Auxiliary** *Center Ballroom*

Friday, May 19

7:00 a.m.	*PharmPAC Breakfast (Everyone is welcome.) *Alfredo's*
8:00 a.m.-1:00 p.m.	Registration *Main Lobby*
9:00 a.m.	**2nd NCPhA BUSINESS SESSION — Second Vice President, J. Frank Burton, Jr., presiding. CE DAY, Program 1: Cholesterol Education Program by Kirk Ways, M.D., East Carolina School of Medicine, Department of Endocrinology. Program 2: "Managing Your Pharmacy's Financial Health" by Jean P. Gagnon, Ph.D., Director of Pharmacy Relations, Marion Laboratories *East Ballroom*

12:00 p.m-1:00 p.m.	Complimentary lunch for Exhibitors in *The Exhibit Hall*
1:00 p.m.-6:00 p.m.	EXHIBITORS FAIR AND LUNCHEON *The Exhibit Hall*
11:00 p.m.	ICE BOX RAID/DESSERT RECEPTION *Pool Terrace*

Saturday, May 20

7:30 a.m.	*1939 Class Reunion Breakfast *Parlours I-IV*
7:30 a.m.	*Christian Pharmacists' Breakfast *Another World*
8:00 a.m.-12:30 p.m.	Registration *Main Lobby*
9:00 a.m.	**3rd NCPhA BUSINESS SESSION — President Al Lockamy, Jr., presiding. Annual Salary Survey presented by Jan Phillips, Ph.D.; NCPhA Committee Reports; Nominations of NCPhA 1990-91 Officers; Executive Director's Report *East Ballroom*
12:30 p.m.	*RECOGNITION LUNCHEON Installation of Officers, Luncheon, 50-Plus Club Inductions and Awards *Center Ballroom*
2:30 p.m.-5:00 p.m.	Academy of Consulting Pharmacists — moderator, Charles Pulliam *Parlours I-IV*
7:00 p.m.	*A NIGHT IN THE ISLANDS featuring a Luau feast and the *Lei Aloha's Polynesian Rainbow Revue Pool Terrace & Deck*

Sunday, May 22

8:00 a.m.	Seminar Registration
9:00 a.m.-3:00 p.m.	SEMINAR: THE PHARMACIST'S ROLE & RESPONSIBILITY IN HEALTH PROMOTION AND DISEASE PREVENTION — Sponsored by NCPhA and NCSHP. Background information on cancer screening and substance abuse recognition and prevention and "how-to" programs for use in your community will be presented. Six contact hours of A.C.P.E. Continuing Education will be provided. Look for details of the seminar program in the mail.

**Reservations for these activities may be purchased through the NCPhA office.*
***All convention registrants are invited to NCPhA's Business Sessions.*

WOMAN'S AUXILIARY BEACH CONVENTION VACATION

North Myrtle Beach Hilton, South Carolina
62nd Annual Convention
May 17-20, 1989
Program

Wednesday, May 17

3:00 p.m.-6:00 p.m.	Registration *Main Lobby*
6:00 p.m.	PRESIDENTS' RECEPTION honoring the Presidents of NCPhA, the Woman's Auxiliary & the Traveling Member's Auxiliary *Pool Terrace*
7:00 p.m.	*OPENING SESSION BANQUET — Master of Ceremonies, President Al Lockamy, Jr. featured speaker, Robert H. Henry presenting, "Win With A.C.E.S., Attitude & Ambition, Commitment, Enthusiasm and Service" followed by Award presentations *Center Ballroom*

Thursday, May 18

7:00 a.m.	Woman's Auxiliary Beach Walk-A-Thon (Everyone is invited to participate.)
10:30 a.m.	Woman's Auxiliary Brunch and Fashion Show by Myrtle Beach's *Victoria's Ragpatch.* **Sponsored by Glaxo, Inc.** *South Deck*
1:00 p.m.	Woman's Auxiliary Shopping Spree at Pawley's Island
1:00 p.m.	GOLF & TENNIS TOURNAMENTS — **Golf sponsored by Owens Brockway, Co-Chairmen, Junior Little & Mike Joyner; Carts by Burroughs Wellcome Co.; Tennis sponsored by Jefferson Pilot, Co-Chairmen, G.N. (Jerry) Brunson & Sam Stuart**
9:00 p.m.-midnight	T.M.A. Dance featuring *THE EMBERS*; cash bar. **Sponsored by the Traveling Member's Auxiliary** *Center Ballroom*

Friday, May 19

8:00 a.m.-1:00 p.m.	Registration *Main Lobby*
8:30 a.m.	Woman's Auxiliary Coffee *Hospitality Room 402*
9:30 a.m.	Woman's Auxiliary Business Session *West Ballroom*
12:00 p.m.	Woman's Auxiliary Luncheon featuring *The First Resort*, A Sweet Adelines Barbershop Quartet. **Sponsored by Burroughs Wellcome Co.** Installation of Officers will follow the luncheon. *Another World*
11:00 p.m.	ICE BOX RAID/DESSERT RECEPTION *Pool Terrace*

Saturday, May 20

8:00 a.m.-12:30 p.m.	Registration *Main Lobby*
12:30 p.m.	*RECOGNITION LUNCHEON Installation of Officers, Luncheon, 50-Plus Club Inductions and Awards *Center Ballroom*
7:00 p.m.	*A NIGHT IN THE ISLANDS featuring a Luau feast and the *Lei Aloha's Polynesian Rainbow Revue Pool Terrace & Deck*

**Reservations for these activities may be purchased through the NCPhA office.*
***All convention registrants are invited to NCPhA's Business Sessions.*

TRAVELING MEMBER'S AUXILIARY BEACH CONVENTION VACATION

North Myrtle Beach Hilton, South Carolina
74th Annual Convention
May 17-20, 1989
Program

Wednesday, May 17

3:00 p.m.-6:00 p.m.	Registration *Main Lobby*
6:00 p.m.	PRESIDENTS' RECEPTION honoring the Presidents of NCPhA, the Woman's Auxiliary & the Traveling Member's Auxiliary *Pool Terrace*
7:00 p.m.	*OPENING SESSION BANQUET — Master of Ceremonies, President Al Lockamy, Jr. featured speaker, Robert H. Henry presenting, "Win With A.C.E.S., Attitude & Ambition, Commitment, Enthusiasm and Service" followed by Award presentations *Center Ballroom*

Thursday, May 18

7:30 a.m.	Traveling Member's Auxiliary Breakfast *Staff Conference Room*
7:30 a.m.	V.I.P. Breakfast *West Ballroom*
8:00 a.m.-1:00 p.m.	Registration *Main Lobby*
1:00 p.m.	GOLF & TENNIS TOURNAMENTS — **Golf sponsored by Owens Brockway, Co-Chairmen, Junior Little & Mike Joyner; Carts by Burroughs Wellcome Co.; Tennis sponsored by Jefferson Pilot, Co-Chairmen, G.N. (Jerry) Brunson & Sam Stuart**
9:00 p.m.-midnight	T.M.A. Dance featuring *THE EMBERS*; cash bar. **Sponsored by the Traveling Member's Auxiliary** *Center Ballroom*

Friday, May 19

7:00 a.m.	*PharmPAC Breakfast (Everyone is welcome.) *Alfredo's*
8:00 a.m.-1:00 p.m.	Registration *Main Lobby*
11:00 a.m.	Traveling Member's Auxiliary Business Session *Parlours I-IV*
12:00 p.m.-1:00 p.m.	Complimentary lunch for Exhibitors in *The Exhibit Hall*
1:00 p.m.-6:00 p.m.	EXHIBITORS FAIR AND LUNCHEON *The Exhibit Hall*
11:00 p.m.	ICE BOX RAID/DESSERT RECEPTION *Pool Terrace*

Saturday, May 20

8:00 a.m.-12:30 p.m.	Registration *Main Lobby*
12:30 p.m.	*RECOGNITION LUNCHEON Installation of Officers, Luncheon, 50-Plus Club Inductions and Awards *Center Ballroom*
7:00 p.m.	*A NIGHT IN THE ISLANDS featuring a Luau feast and the *Lei Aloha's Polynesian Rainbow Revue Pool Terrace & Deck*

**Reservations for these activities may be purchased through the NCPhA office.*
***All convention registrants are invited to NCPhA's Business Sessions.*

Robert H. Henry

Jean Paul Gagnon, Ph.D.

Jan Hirsch Phillips, Ph.D.

Walter L. Fitzgerald, Jr.

Kirk Ways, M.D.

FEATURED NCPhA CONVENTION SPEAKERS

Robert H. Henry is scheduled to be the speaker at the "Opening Session Dinner," one of NCPhA's most well attended convention events. Mr. Henry has been recognized as one of America's busiest and most charismatic speakers and has enthralled audiences both in the U.S. and abroad. He is highly respected by his peers, having received the 1988 Cavett Award, which is the highest award possible for a professional speaker, the equvilavent of an Oscar for actors.

Mr. Henry will present an inspirational speech, entitled "Win With A.C.E.S.," (an acronym for Attitude and Ambition, Commitment, Enthusiasm, and Service).

Mr. Henry is a pharmacist by education and has served as Director of Pharmacy Operations at the Medical College of Virginia and Director of Professional Affairs for the United States Pharmacopeia in Washington, D.C.

It is a great honor for NCPhA to have this multi-talented individual and award winning speaker, Mr. Robert H. Henry, at our Opening Session Dinner.

Walter L. Fitzgerald, Jr. is both a licensed pharmacist and attorney at law. He is an associate professor of Pharmacy Administration at the University of Tennessee College of Pharmacy where he teaches courses in health care law, with emphasis in the areas of pharmacy and drug law. In addition to his responsibilities at the University, Mr. Fitzgerald is executive director and general counsel to the American College of Apothecaries and engages in the private practice of law in Memphis. He is currently the author of law columns in *The Apothecary* and the *Tennessee Pharmacist.*

In his presentation, "Legal Issues Associated with Expanded Roles for the Pharmacist with Regard to Patient Services," Mr. Fitzgerald will focus on wellness education, drug consultation-education, and screening program such as, hypertension screening and diabetes testing. Mr. Fitzgerald has conducted extensive research on this topic with emphasis on the application of various laws to medical and pharmacy practice.

For those of you who are currently providing expanded patient services or if you can envision yourself providing these expanded services in the foreseeable future you will want to understand the legal issues surrounding pharmacist participation in these services.

Jean Paul Gagnon, Ph.D., Director of Pharmacy Relations at Marion Laboratories (former Tar Heel) is back again this year by popular demand to teach us more computer applications. In his talk entitled, "Managing Your Pharmacy's Financial Health," Dr. Gagnon will demonstrate and explain how to use spreadsheet templates to assist you in monitoring the financial condition of your pharmacy. The templates exist as separate files that are loaded into a compatible spreadsheet program such as LOTUS 1-2-3 or Multiplan. The templates enable you to:

- enter important data needed for financial analysis
- calculate automatically key totals, ratios, and percentages
- compare current financial results to that of prior years and to industry norms
- process data for budgeting, purchasing, and other operations
- perform pro forma and "what if" calculations
- prepare standard financial and operational reports.

Program participants will receive a free guide book and a floppy disk containing the templates (compliments of Marion Labs) which can be loaded into either your LOTUS or Multiplan compatible software programs at work or at home. This is one presentation you will definitely not want to miss.

Kirk Ways, M.D. will present "Diagnosis and Management of Lipid Disorders." The presentation will focus on the new guidelines on hyperlipidemia set forth by the Heart, Lung and Blood Institute of the National Institutes of Health. Special emphasis will be placed on defining the need for pharmacologic intervention and the drugs used to treat these disorders.

Dr. Ways is an Assistant Professor of Medicine in the Section of Endocrinology and Metabolism at the East Carolina School of Medicine in Greenville, North Carolina. He serves as the Director of Medical Education for the Section of Endocrinology and Co-Director of the Lipid Clinic at the East Carolina School of Medicine. He has conducted extensive research, programs and lectures in the area of endocrinology as well as authored numerous publications.

Jan Hirsch Phillips, Ph.D. will review results of the 1988 Salary Survey organized by the UNC School of Pharmacy, in conjunction with the

Continued on page 37

The Embers

Lei Aloha's Polynesian Rainbow Revue

THE NORTH CAROLINA PHARMACEUTICAL ASSOCIATION BEACH CONVENTION VACATION

North Myrtle Beach Hilton, South Carolina
1989 Annual Convention
May 17-21

ACTIVITIES GUIDE

Woman's Auxiliary Beach Walk-A-Thon, Thursday, May 18, 7:00 A.M. Everyone is invited to participate in this walk on the beach. Find any number of sponsors for this event who will reimburse you for an agreed upon price per mile you walk. The proceeds for this event will go to the Woman's Auxiliary pharmacy projects, scholarships, and The Consolidated Student Loan Fund.

Golf Tournament, Thursday, May 18, 1:00 p.m., at the Arcadian Shores, *Par Excellence*, Golf Club near the North Myrtle Beach Hilton. **Sponsored by Owen's Brockway; Co-Chairmen, Junior Little & Mike Joyner; Carts provided by Burroughs Wellcome Co.**

Tennis Tournaments, Thursday, May 18, 1:00 p.m., at the hotel's tennis center. **Sponsored by Jefferson Pilot; Co-Chairmen, G.N. (Jerry) Brunson & Sam Stuart.**

T.M.A. Dance, Thursday, May 18, 9:00 p.m.-midnight, featuring *The Embers* in the Center Ballroom. You will want to dress up for this evening affair (cocktail attire) but be prepared to kick off your dancing shoes after the band warms up. **Sponsored by the Traveling Member's Auxiliary.**

Ice Box Raid/Dessert Reception, Friday, May 19, 11:00 p.m.-? On the Pool Terrace. After a full day of meetings and a free evening (you are on your own for dinner), everyone is invited to meet back at the hotel for a late night get-together flavored with an ice cream buffet and desserts galore!

A Night in the Islands, Saturday, May 21, 7:00 p.m., by the pool. A Luau feast will be provided along with the Hawaiian entertainment group, *Lei Aloha's Polynesian Revue*. This Hawaiian group will perform traditional dances from Tahiti, Samoa, New Zealand, and Hawaii. Fire dancers will also be part of the show! *Reservations are required for this event and may be obtained through the NCPhA office.*

ATTENTION PHARMACISTS LICENSED 50 YEARS OR MORE

If you have been a licensed pharmacist for 50 years or more you are eligible for induction into the ***50-Plus Club***. Inductees will be recognized at the Awards Luncheon during the 1989 NCPhA Annual Convention at the North Myrtle Beach Hilton in South Carolina, May 20th. Please let us know if you are deserving of membership to this elite group of pharmacists who have served in their profession for 50-plus years! Contact Mr. Al Mebane at NCPhA: 1-800-852-7343 (in-state).

CALL FOR CONVENTION DELEGATES AND OFFICIAL CONVENTION REPRESENTATIVES

If you are planning to attend the 1989 APHA Annual Meeting in Anaheim, CA, April 8-12, and would like to represent NCPHA as a convention *Delegate* **and/or** if you would like to be an *Official Representative* for your local association or society at the 1989 Annual NCPhA Convention, May 17-21, at sunny South Carolina's North Myrtle Beach Hilton. Contact Mr. Al Mebane at 1-800-852-7343.

NCPhA OFFICERS to be INSTALLED at ANNUAL CONVENTION

President
Ralph H. Ashworth, *Cary*

First Vice President (President-Elect)
J. Frank Burton, Jr., *Greensboro*

Second Vice President
Betty H. Dennis, *Carrboro*

Third Vice President
Stephen C. Dedrick, *Durham*

Executive Committee
Member At Large
J. Robert Bowers, *Bethel*
W.P. O'Neal, Jr., *Belhaven*
Laura McLeod Vance, Winston-Salem

"I heard a noise that sounded like jets . . . then I heard the K-Mart next door blow up. I thought we were being bombed," Terri Mayo.

K-Mart pharmacist, Shelby Kimble (right), stands in the middle of what once was the pharmacy where she worked.

Although much of the building surrounding the K-Mart pharmacy on U.S. 70, was collapsed by the tornado, beakers, books, and medicines remain virtually untouched on the pharmacy shelves. In the upper left hand corner of the photograph, the sky peers through the open walls of the building.

PHARMACISTS TOUCHED BY TORNADO IN RALEIGH

When a tornado slashed through northwest Raleigh and into northern Franklin County on November 28, 1988 dozens of persons were injured, 4 persons were killed, and damages to homes and businesses totaling $100 million remained. Among those touched by the tornado were pharmacists, Terri Mayo, Randy Ball, Lynn Coats, and Shelby Kimble and James Baggett, all of Raleigh.

Terri Mayo, a State Board of Pharmacy Inspector for Alamance, Wilson, and Roberson counties, was awakened by the tornado shortly after 1:00 a.m. early Monday morning. "I heard a noise that sounded like jets," she said. "The front door opened and then I heard the K-Mart next door blow up. I thought we were being bombed." Terri lived at the Coopers Pond Apartments on Pleasant Valley Road. (She has sinced moved into a new house which was previously under construction.)

Her husband, Deputy Clarence Mayo, a Wake County sheriff, was on duty at the time the tornado hit. He was traveling in his patrol car on U.S. 70 when his car was picked up and turned 180 degrees in the opposite direction. Tree branches pierced his windows. He was left unhurt, and spent the remainder of the night assisting others not so fortunate.

Once the sounds of the night seemed to have quieted down, Terri called her brother, Randy Ball for help. He left his home around 1:30 a.m. to go aid his sister in need. As he neared the apartments where his sister lived, traveling became more and more difficult. The roads were flooded from the heavy rains and trees were strewn everywhere. "I couldn't believe the devastation," Randy said. "The landscape and entire buildings had been rearranged." When he finally reached Terri, he discovered that she and her apartment were okay, although the buildings around her were badly damaged. She was lucky; her only loss was her electric power. Both were thankful, but painfully reminded "just how fragile we are compared to nature," Randy commented.

Having been reassured of his sister's safety, Randy set out to help her neighbors who were not so fortunate. He soon learned that the path of destruction, caused by the tornado, extended far beyond his sister's neighborhood. The tornado had traveled as far as the Celebration At Six Forks Shopping Center where Randy is the pharmacist manager at the center's Revco pharmacy.

He quickly departed for the store and when he arrived, also found it intact. Again, however, neighbors across the street in the dental office building were not so lucky. Randy helped the dentists sift through the rubble until nearly daybreak.

When he could do no more for his neighbors, Randy went home for a quick shower and returned to his pharmacy. His customers started coming by his pharmacy long before the store was supposed to open. He helped them by getting batteries, distilled water, medicines, and other supplies out of the store.

As the week progressed, Randy said, "the store became sort of a clearinghouse where customers came in to ask about others in the surrounding area, exchange war stories, and to find out about those who were in need." Randy and Lynn Coats, the other pharmacist who works at the Revco pharmacy, spent the rest of the week helping customers get their prescription medicines back in order that were lost in the tornado.

Meanwhile, Shelby Kimble and James Baggett, pharmacists at the K-Mart store on U.S. 70, had to wait several days before workers were able to clear a path to their pharmacy. It wasn't until Friday afternoon that workers finally penetrated the pharmacy. Terri Mayo was present when they did. Her assessment of the pharmacy area was, "Incredible." "None of the beakers were broken; they still remained on the shelf where they belonged. Many of the pharmacy's reference books did, also, despite the destruction surrounding the pharmacy. None of the pharmacy's records were lost either," Terri reported.

Now all that remains of the K-Mart store is an empty parking lot. All of the debris has been completely removed by the K-Mart company and both pharmacists have been relocated to other K-Mart stores in the Raleigh area.

Others in the pharmacy business generously provided aid to tornado victims: Kerr Drug Stores supplied close to $6,000 worth of personal care items, pillows and blankets, Burroughs Wellcome donated $50,000, and Glaxo, Inc. donated $100,000.

THE LOWER RESPIRATORY TRACT—

More vulnerable to infection in smokers and older adults

Experience counts

Ceclor® Pulvules® 250 mg
cefaclor

think of it first

For respiratory tract infections due to susceptible strains of indicated organisms.

See adjacent page for brief summary of prescribing information.

Lilly

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Ceclor®
cefaclor

Summary.
Consult the package literature for prescribing information.
Indication: Lower respiratory infections, including pneumonia, caused by *Streptococcus pneumoniae, Haemophilus influenzae,* and *Streptococcus pyogenes* (group A β-hemolytic streptococci)
Contraindication: Known allergy to cephalosporins
Warnings: CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.
Administer cautiously to allergic patients.
Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.
Precautions:
• Discontinue Ceclor in the event of allergic reactions to it.
• Prolonged use may result in overgrowth of nonsusceptible organisms.
• Positive direct Coombs' tests have been reported during treatment with cephalosporins.
• Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
• Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
• Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.
Adverse Reactions: (percentage of patients)
Therapy-related adverse reactions are uncommon. Those reported include:
• Gastrointestinal (mostly diarrhea), 2.5%.
• Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
• Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, and serum-sickness-like reactions that have included erythema multiforme [rarely, Stevens-Johnson syndrome] and toxic epidermal necrolysis or the above skin manifestations accompanied by arthritis/arthralgia, and frequently, fever): 1.5%, usually subside within a few days after cessation of therapy. Serum-sickness-like reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.
• Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
• As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
• Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.
• Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%; and, rarely, thrombocytopenia.
Abnormalities in laboratory results of uncertain etiology:
• Slight elevations in hepatic enzymes.
• Transient fluctuations in leukocyte count (especially in infants and children).
• Abnormal urinalysis; elevations in BUN or serum creatinine.
• Positive direct Coombs' test.
• False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clinitest® tablets but not with Tes-Tape® (glucose enzymatic test strip, Lilly).
I042188LI
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Additional information available from Eli Lilly and Company, Indianapolis, Indiana 46285

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Carolina, Puerto Rico 00630

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PharmaDates

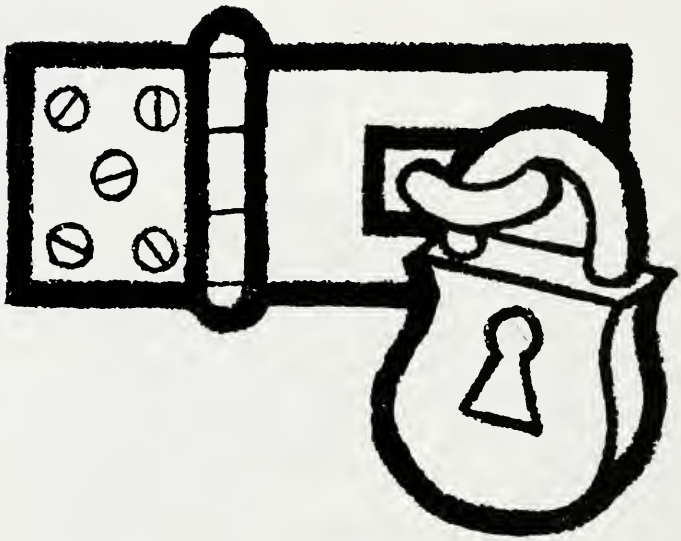
1989

March 19-25	NATIONAL POISON PREVENTION WEEK
March 20	Board of Pharmacy Reciprocity Examination
March 21	Board of Pharmacy Meeting
April 8-13	APhA Annual Meeting, Anaheim, CA
April 18	Board of Pharmacy Meeting
May 15	Board of Pharmacy Reciprocity Examination
May 16	Board of Pharmacy Meeting
May 17-20	**NCPhA Annual Convention, North Myrtle Beach, SC**
May 21	***NCPhA/NCSHP Seminar, North Myrtle Beach, SC**
June 4-8	ASHP Annual Meeting, Nashville, TN
June 20	Board of Pharmacy Meeting
June 26-27	Board of Pharmacy Licensure Examination

*Note: The NCPhA/NCSHP Seminar was previously scheduled on Wednesday, May 17, 1989. It has been changed to Sunday, May 21, 1989.

NATIONAL POISON PREVENTION WEEK March 19-25, 1989

LOCKED UP POISONS



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February, 1989

Professionalism— It Means Different Things to Different People

This is the third in a series of articles for professionals who manage and managers who lead professionals and those who are both. Pharmacists operate with one license, but fill many different professional roles in hospitals, chain stores, indiviudal stores, drug companies and universities. Along the way they need a broad variety of management skills. These articles take a broad poerspective on management concepts we hope you will be comfortable applying.

Curtis P. McLaughlin

Everyone wants to be a professional. We read about police professionals, health professionals, and professionals entering the Olympics. What does it all mean? First of all the word, *professional*, obviously means different things to different people or to the same person under different circumstances. There are two primary definitions of the word. The first refers to a member of a profession or conducting oneself the way a responsible professional would behave. The second is someone who does for pay what others would normally do for pleasure — the amateur vs. professional dichotomy. The latter meaning gives us a "professional killer" or "the oldest profession on earth." The former denotes a position sanctioned by society with its own rites and rituals, its own body of knowledge, its freedom to restrict entry to the qualified or initiated, a code of conduct, and the right to police its own domain. It is certainly the latter that most would apply to pharmacy. But it is important to recognize that the public has been and is confused about this at times.

A second thing to recognize is that the public defines what a profession is and not the members of the profession. This is a fact of life that all professionals must remember. When it comes to the respect that the public affords a profession, the public giveth and the public taketh away.

The only professions with an iron-clad grip on professional status have been the lawyer, the priest (or minister) and the physician. Other professions have had an uphill struggle, witness the school teacher and the military officer corps. One barometer is the right of client confidentiality. Only the lawyer, priest or physician have an absolute right. Journalists have been in continuous court battles over this. Nurses, school teachers, and social workers have ended up as what Amatai Etzioni calls "semiprofessions." The nurses remain dominated by physicians and the latter two by the power of the public purse.[1]

The power of the professions can be extensive. Only a physician can declare anyone dead and can exercise other police powers. Credentialing helps, but it is not enough. The hospital administrator needs to have credentials, but is seldom referred to as a professional and has never achieved the right to restrict entry through licensure. Licensure is not enough. Many health personnel are licensed, but have lacked professional autonomy.

A profession's power appears to come from two factors: "disinterestedness" and the inability of the public or the public's representatives to judge performance. Disinterestedness implies a willingness to ascribe to the goals of the service and not to personal gain, to look out for the best interests of the client. It may even mean a

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CURTIS P. MCLAUGHLIN is a Professor of Business Administration in the School of Business and Professor of Health Policy and Administration in the School of Public Health at the University of North Carolina at Chapel Hill. McLaughlin received his masters and doctorate degrees in Business Administration from Harvard Business School. He has written numerous management articles for a variety of publications, including Harvard Business Review, and has consulted for domestic and international corporations. Some of his professional interests include the production of professional services in research, engineering, medicine, public health and education; management of not-for-profit organizations; and productivity improvement.

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PROFESSIONALISM

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willingness to reduce fees to meet client resources. Given a monopoly authority, but one tempered by disinterestedness, the profession can presumably be left free to set its own fee schedules, restrict competitive behaviors affecting client interests, and avoid defending itself in the usual public forum.

The biggest source of power, however, is the inability of the public or its representatives to assess the professionals' performance. If they cannot assess it, they must turn that role over to those who can, the insiders.

Eliot Friedson, the medical sociologist, writes:

> But unlike bureaucratic practices, in which rational-legal orders are considered arbitrary and subject to appeal and modification, professional practices are imputed the unquestioned objectivity of expertise and scientific truth, and so are not routinely subject to higher review or change by virtue of outside appeal. Here is the crux of the matter. Expertise is not merely knowledge. It is the *practice* of knowledge, organized socially and serving as the focus of the practitioner's commitment. . . . The worker . . . develops around it an ideology and, with the best of intentions, an imperialism which stresses the technical superiority of his work and of his capacity to perform it. This imperialistic ideology is built into the perspective that his training and practice create. It cannot be overcome by ethical dedication to the public interest because it is sincerely believed in as the only way to serve the public interest. And it hardens when an occupation develops the autonomy of a profession and a place of dominance in a division of labor, and when expertise becomes an institutional status rather than a capability.[2]

Yet the fact remains that the public is not comfortable with the possibility that it is sending the fox to guard the hen house. Americans especially are not likely to suffer this situation meekly. As Andrew Hacker points out,

> the new American is informed, educated and possessed of far greater sophistication than any nation's ordinary citizen has ever before been. . . . Americans talk a great deal more — and in a common language — than was ever the case previously. These conversations, moreover, center on subjects once exempted from argument and examination. An atmosphere pervaded by conversation is bound to undermine agencies of control. . . . Hardly any area of public or private life is now immune from scrutiny. . . . The fact is that the egos of two hundred million Americans have expanded to dimensions never before considered appropriate for ordinary citizens.[3]

If Hacker is correct, professions are all in a decline, since the public believes that it is able to evaluate anything. That appears to be the case. Even those who are illiterate often have access to health information by electronic media. All of the bastions of professionalism are under seige from malpractice (where a jury decides with lots of advice available) to self-help books to *Readers Digest* medicine. Specific examples are easy to cite in pharmacy — malpractice suits, mailorder prescriptions, and the bypassing of pharmacists by other professionals. Pharmacists, like all professionals, must earn the respect of the public every day. Even though one can influence public perceptions through the media, the real issue is that of deciding how we would like to be seen by the public and then living out that image.

The leadership of the profession must ask itself the following questions. What would we like the public to see as our professional behavior? What should we undertake to be disinterested? What is the unique competence in practice that we have that the public will value? How might we demonstrate that value? How do we undermine it? To what extent is its image in our hands?

In each of those areas it is further useful to ask the following questions. What are qualifiers for our profession, things that we can't be in the race for public acceptance without? What are losers, things that, if we don't do well, will turn off the public? What are the things that keep us from appearing disinterested and from appearing to have unique expertise? And most importantly, what are winners? What are the things that, if we deliver, will assure us success in the eyes of the public? Once those are defined, the profession can pull together with its educational, licensure and socialization processes to develop behaviors that assure the winning of greater public status and greater professional autonomy.

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1. Amatai Etzioni, *The Semiprofessions and Their Organization: Teachers, Nurses and Social Workers*, New York: The Free Press, 1969.

2. Eliot Friedson, "Dominant Professions, Bureaucracy, and Client Services," in W.R. Rosengren and M. Lefton, eds. *Organizations and Clients: Essays in the Sociology of Service*, Columbus, OH: Charles E. Merrill, 1970, pp. 91-92.

3. Andrew Hacker, *The End of an American Era*, New York: Atheneum, 1970, pp. 31-32, 214.

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AROUND THE STATE

In response to the recent Readers' Survey conducted by The Carolina Journal of Pharmacy, this column, featuring news around the state, has been resurrected from the past. The NCPhA staff welcomes your comments and any contributions you wish to make to this column. Photos are also welcome. Send us your news!

Awards, Honors, Citations

Robert Wheeler, owner of Creedmoor Drug Company, was elected to the Central Carolina Board of Directors in Creedmoor. He has served as President of the Creedmoor Chamber of Commerce for two terms and is on the Chamber's Board of Directors. He is also on the Business and Industry Advisory Council for Granville County Schools. He and his wife, Debra, have one son, Robby, and live in Creedmoor.

Wallace Nelson, Director of Pharmacy at Chowan Hospital in Edenton, received the certificate of appreciation from College of The Albemarle (COA) for serving as a member of the board of directors for the COA Foundation, Inc. In addition to serving on the Foundation board, Nelson is serving a four-year term on COA's board of trustees.

Pedro Cuatrecasas, director of research and development at **Glaxo, Inc.**, was the recipient of the 1988 North Carolina Award for science. The North Carolina Award is the highest honor the state can bestow. He and his wife, Carol, live in Chapel Hill. Among the 1988 North Carolina award recipients was newsman and former NC native, David Brinkley.

Taylor's Pharmacy of Gates was honored at the Albemarle Area Development Association Awards Banquet on November 29, 1988. Awards were presented to businesses and organizations throughout the 10 counties in the Albemarle area that have contributed to the economic development of their communities.

Ted G. Gupton, pharmacist at Harris Pharmacy in Louisburg, was appointed to the Franklin County Board of Education on December 21, 1988. He will represent the Cyprus Creek/Gold Mine townships. Gupton and his wife, the former Judy Mullen of Bunn, have a daughter, Susan, age 6. Mrs. Gupton has taught at Louisburg Elementary School for 17 years.

Students from the UNC School of Pharmacy have been awarded first place in the National Pharmacy Intercollegiate AIDS Awareness Competition which included a $2,500 donation to the pharmacy scholarship fund. Accepting the award were **Joseph Abdalla** of Smithfield, **Cori Hefter** of Cary, and **Dana Kiser** of Cherryville. Students helped organize seminars, campus information booths, fact sheets, and a system allowing students to obtain answers to questions about the AIDS confidentially. The **Burroughs Wellcome Co.** provided funding for the UNC project.

In the News

Gerald Mizelle, owner of Roanoke River Pharmacy in Plymouth, merged with the Rite Aid Corporation in November 1988. All of his prescription files and patient records were transferred to the Rite Aid Pharmacy located at Ames Towne Plaza in Plymouth. Mizelle will work as one of the pharmacists at the Rite Aid store.

Steven Novak, chief pharmacist of Gaston Memorial Hospital, talks regularly to consumer groups about the importance of using prescription drugs correctly. In a recent interview conducted by a reporter with the Gastonia Gazette, Novak described what he tells his consumer groups, such as features consumers should look for when choosing a pharmacy. Novak emphasized the importance of pharmacist communication with customers about their prescription medications and the advantages of choosing one pharmacy.

Biochemie, a subsidiary of the Austria-based Sandoz AG, is considering building its first U.S. plant in Raleigh or Garner. Company officials will not reach a decision, however, until May 1989. Like its Austrian parent company, the proposed plant would most likely produce antibiotics.

Reynolds Health Center pharmacy in Winston-Salem is undergoing a $29,000

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AROUND THE STATE

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renovation project. Pharmacy director, **Janet Foster**, said the major change will be the addition of a consultation room that will offer a private area for pharmacists to counsel patients about their medications.

Glaxo, Inc. plans to open a $90 million pharmaceutical manufacturing plant on the site of the former American Tobacco Inc. operation in downtown Durham. The company will produce antibiotic tablets at the plant. Glaxo also has a manufacturing plant in Zebulon and is in the midst of building a $300 million research facility at its RTP headquarters.

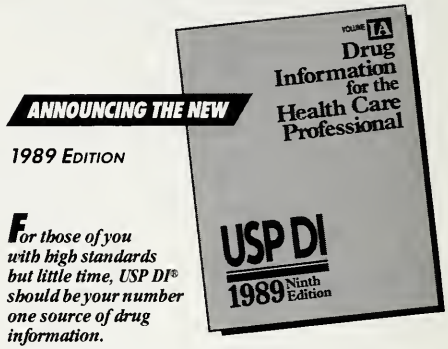
The pharmacy at the **Crisis Control Ministry** in Winston-Salem is undergoing a 625-square-foot addition. The addition, which includes two interview rooms and a new dispensary, was financed with private grants and donations. The pharmacy first opened in March 1986 in a closet-sized room. Medicines are donated by drug manufacturers, hospitals, and local doctors and purchased with monies donated by local businesses. Local pharmacists and doctors donate their time to dispense the free medicines and provide free medical care.

UNC pharmacy students, **Hugh Galloway**, **Cori Hefter**, and **Joey Pippin**, recently presented a program about the use of drugs to Central Elementary's fourth and fifth grade classes in Hillsborough. Their presentation included a rap about drugs, skits about the use of drugs, and a discussion which included a question and answer period. The UNC students regularly conduct the program to surrounding schools.

Commentary entitled, *It's Time To Take The Next Step*, by **David R. Work**, Executive Director of the NC State Board of Pharmacy, appeared in the January issue of *American Pharmacy*. In his article, Mr. Work questions FDA barriers to direct-to-consumer advertising of specific prescription drugs, as brand name manufacturers have begun promoting the availability of drugs for treating certain conditions.

Crime Reports

A man armed with a sawed-off, bolt-action type weapon took narcotics and a small amount of money from the Eastgate Medical Center pharmacy in Sylva. The man fled in a Jeep Cherokee belonging to one of the pharmacists. Although the vehicle was later recovered, the man is still at large.



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DICKINSON'S PHARMACY
(by Jim Dickinson)

Lowered expectations. If one of your professional satisfactions has come from the fact that public opinion polls repeatedly rank pharmacists at the top of the ladder of public esteem, consider this: It may be that the public is easy to please, pharmaceutically speaking.

West Virginia University pharmacy lawyer David B. Brushwood is among those who believe that, if true, this is a dangerous situation for the profession. A clientele that expects little may be satisfied by anything, including vending machines and mail-order suppliers.

If there is one pharmaceutical domain that can always be reserved exclusively for the live, flesh-and-blood pharmacist in one-on-one patient encounters it is that area where professional discretion is exercised — to dispense or not to dispense?

Brushwood has recently authored a videotape presentation for all pharmacy schools, "Ethics Perspectives," which dramatizes the ethical dilemmas that confront practicing pharmacists.

Consisting of 10 vignettes and 10 lengthier scenarios, the videotape addresses such topics as the monitoring of medical treatment, patient rights, disclosure of patient information, compliance with physician intentions, and current socioeconomic concerns.

One situation on the tape proposes that you have been filling prescriptions for an elderly couple for years, and know that the wife has Alzheimer's disease while the husband has been in stable health.

Recently, the health of both deteriorate. One day, the husband jokingly asks how much of his heart medication it would take to kill his wife. What should you say or do?

Brushwood's advice on the tape is to first contact the patient's physician.

"If the physician does not take action, the pharmacist is put into a unique situation," Brushwood told West Virginia University's magazine, *Pylons*. "In this case the husband is a competent decision maker and has the right to lead his life as he pleases. The wife, however, is not a competent decision maker because she is suffering from Alzheimer's. If the pharmacist suspects that the husband may endanger his wife's life, the pharmacist has a duty to intervene by informing the other family members."

Brushwood is among a growing number of thoughtful pharmacists who believe the profession has been given an easy, if not a

James G. Dickinson

privileged, ride in the societal changes that have been taking place for at least the past several decades.

As pharmacy technicians, dispensing physicians, mail-order firms and even 7-Elevens (via Rx-to-OTC switches) muscle into pharmacy's traditional "turf," the profession's comfort zone is being disturbed.

An understandable gut reaction has been to use political muscle in the opposite direction —to seek legislated bans on physician and mail dispensing, for instance.

Nice work, if you can do it. But increasingly in our pluralistic society, legislators are reluctant to interfere with anyone's way of making money —unless there is a convincing "body-count."

And even in the presence of body-count, the tendency is to write rules as liberally as possible, so as to interefere as little as possible. The most recent case in point is the Prescription Drug Marketing Act of 1988 that pharmacy hoped would eliminate multi-tier pricing while eliminating the diversion market; instead, the law, as passed narrowly, limits only the most excessive (and least extensive) abuses — and it does so in a

Continued on page 33

James G. Dickinson . . . Who is this mystery man? Mr. Dickinson's column, Dickinson's Pharmacy, has been running in our journal for the last two years. His column is syndicated and appears monthly in many state pharmaceutical journals across the country. Mr. Dickinson is also editor and publisher of Dickinson's FDA and Dickinson's PSAO industry newsletters. He has served as assistant executive director of the American Pharmaceutical Association and Washington bureau chief for Drug Topics. His home is in Morgantown, West Virginia.

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DICKINSON'S PHARMACY

Continued from page 31

manner so feeble that cynics believe nothing will change in the long-run.

Discriminatory pricing, in other words, is still with us, and so is the broader diversion market, which is now sanitized under the euphemism, "secondary source market."

The law is still an achievement in protecting public health — but protecting pharmacy is not one of the things it does.

So if you can't get the law to protect you, who can you turn to? The answer has been known since Shakespeare: "The fault, dear Brutus, lies not in our stars but in ourselves if we are underlings."

In other words, do not let the low expectations of the public in the past and third-party payors now, deter us from accepting Professor Brushwood's challenge.

It is in the risky area of decision-making, and the exercise of professional discretion, displayed most conspicously in the counseling function, that pharmacy will succeed or fail in the future.

Do you dispense that partial refill for the traveler late on a Friday night? Do you invite a physician's patient to question his or her prescription? Do you divulge a patient's disease condition to that caller on the phone?

What are the trade-offs? By the quality of their judgments will pharmacists preserve the status of their profession — not by repackaging dosage units on the low expectations of purchasers.

This feature is presented on a grant from G.D. Searle & Co., in the interests of promoting the open discussion of professional issues in pharmacy. G.D. Searle & Co. accepts no responsibility for the views expressed herein as they are those of the author and not necessarily those of G.D. Searle & Co.

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The North Carolina Pharmaceutical Association has arranged with *Pharmacist's Letter* for members to be able to subscribe at a reduced rate. *Pharmacist's Letter* is an advisory service for practicing pharmacists. Subscribers to the service get a monthly newsletter and access to the Pharmacy Information Center for more information on the subjects covered in the *Letter.* The *Letter* covers a variety of new developments in pharmacy. Typically subscribers will learn new ways of using drugs, newly recognized drug interactions, what the consumer magazines are telling readers, and new trends in practice. For example, a recent issue told subscribers how to get a brand new cholesterol testing card that can't be sold to the public but can be used by pharmacists and other health professionals so that pharmacists can offer a cholesterol screening program without using any laboratory equipment.

Subscribers also get free items through the Pharmacy Information Center. For example, subscribers were recently offered wall charts from Cetus Corporation showing drug interactions with the chemotherapy drugs, a brochure from the American Heart Association showing what antibiotics dentists should use to prevent endocarditis, and a booklet from the FDA about diet and a healthy heart. These materials are for use in the pharmacy, or to give to physicians, dentists, and nurses, or to provide to consumers.

Pharmacists also learn how to react to new developments. When *Pharmacist's Letter* alerted subscribers that iron supplements may interact with methyldopa, the *Letter* also recommended how to avoid the problem. Often times the essence of several articles in journals like the *New England Journal of Medicine*, or the *Journal of the American Medical Association* are interpreted into two or three easy-to-read paragraphs in *Pharmacist's Letter.*

The *Letter*'s editor, Jeff Jellin, says *"Our job is to find out every bit of valuable new information that pharmacists need each month to survive and then give it to them in a form that they can absorb when they catch a few free minutes."*

Each member will receive a packet of information about *Pharmacist's Letter* in the mail during February. Members can subscribe for $52.

For more information you can contact *Pharmacist's Letter* at 5075 Cozad, Stockton, CA 95212 (209) 931-2923.

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INSURANCE / FINANCIAL SERVICES

CONVENTION SPEAKERS

Continued from page 15

North Carolina Pharmaceutical Association. Dr. Phillips will examine pharmacists' salaries, benefits, working conditions, and job satisfaction in North Carolina and compare the results with the data obtained from the previous 1978 and 1980 studies.

All pharmacists should attend this presentation to learn how their salaries, benefits, working conditions, and job satisfaction compare to others in different pharmacy practice settings. Trends in these aspects of practice between 1978 and 1988 will also be discussed.

Dr. Phillips is an assistant professor in the Department of Pharmacy Administration at the UNC School of Pharmacy. Besides teaching, her interests include research in marketing innovative pharmacy services, marketing management in community pharmacies and the pharmaceutical industry, and assessing the supply and demand for pharmacist manpower.

Welcome, New Members!

Howard I. Duckworth, Jr., Morganton
Beverly A. Clark, Wilmington
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Lynn Cooke, Raleigh
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Claudia R. Webb, Cleveland
Sandra K. Wilkins, Goldsboro
Linda E. Baker, Carrboro
Joan L. Finger, Lexington
Carolyn N. Folwell, Chapel Hill
Vikki Watts, Tabor City

LEGAL UPDATE

Prescription Drug Marketing Act of 1987

Submitted by Robert L. Gordon, R.Ph., Director, Food & Drug Protection, North Carolina Department of Agriculture, James A. Graham, Commissioner.

The Prescription Drug Marketing Act of 1987 does not affect returns by retail or community pharmacies; however for returns by hospitals, health care entities, and charitable institutions, the following will apply:

Returns by hospitals, health care entities, and charitable institutions when a mistake in ordering or delivery has occurred. A return to a wholesale distributor of a prescription drug received by a hospital, health care entity, or charitable institution because of a mistake or error in ordering or delivery may be interpreted as falling outside the scope of a sale or trade, and may be returned to stock by the wholesale distributor, provided that:

(a) The return is made under proper storage and shipping techniques to the wholesale distributor within 10 working days of delivery, and

(b) The person returning the product provides written notice to the manufacturer that the prescription drug product (identified by product name, lot number, the quantity returned, and the date of the return) has been returned to the wholesaler (identified by name and address) and that notice includes a description of the mistake or error leading to the return and its apparent cause.

Requests for further information or additional clarifications of the new law should be directed to Albert Rothschild in the Division of Regulatory Affairs (HFD-360), Center for Drug Evaluation and Research, Food and Drug Administration, 5600 Fishers Lane, Rockville, Maryland 20857 (telephone: 301-295-8038).

Continuing Education Needs

What would you like to see offered in Continuing Education programs in your part of the state? What specific programs would best serve your professional educational needs? What are you NOT receiving in CE that would be helpful? Please write or call your requests to NCPhA in Chapel Hill. Toll-free 800-852-7343

CLASSIFIED ADVERTISING

Classified advertising is free to members. For nonmembers classified ads are 25 cents a word with a minimum charge of $5.00 per insertion. Ads are accepted for a single issue or specific time period only. The closing date for ad orders is the first of the month preceding the issue in which you are requesting insertion. Payment for ad orders will be billed. Names and addresses will be published unless an ad number for a blind ad is requested. In replying to blind ads, send to Ad Number ( ), *The Carolina Journal of Pharmacy,* P.O. Box 151, Chapel Hill, NC 27514. Telephone 1-800-852-7343 (in state) or (919) 967-2237.

HOSPITAL POSITIONS OPEN

PHARMACIST WANTED: Iredell Memorial Hospital is a modern, community, acute-care hospital with a reputation for excellence. We are adding new pharmacist positions. New schedule reduces evening and weekend shifts. New salary scale. Computerized unit dose, IV Admixture services, and therapeutic drug monitoring programs. New graduates are encouraged to apply. Contact Beverly Wilkerson, Director of Personnel or Dan Dalton, Director of Pharmacy Services, at Iredell Memorial Hospital, P.O. Box 1400, Statesville, NC 28677 (704) 873-5661. You may call collect.

RETAIL POSITIONS OPEN

PHARMACIST WANTED: Pharmacist interested in managing independent store 30 miles north of Charlotte. Closed nights, weekends and holidays. Excellent salary, good benefits and possibility of ownership. Reply to Box TBX, c/o NCPhA, P.O. Box 151, Chapel Hill, NC 27514

PHARMACISTS WANTED: Drug Emporium, Greensboro, NC now hiring pharmacists. Excellent starting salary. Complete benefit package, plus bonuses included. Call Kent Huffman for details at (919) 282-3993.

PHARMACISTS WANTED: Due to rapid growth Kerr Drug Stores now have positions available for pharmacists in Rocky Mount, Kinston, Raleigh, Fayetteville, Mt. Olive, Charlotte, Durham, Havelock, Clayton and Greenville. Kerr Drug offers opportunity for growth into store management. Excellent benefits. Send resume to Jackie Gupton, P.O. Box 61000, Raleigh, NC 27661, or call (919) 872-5710.

PHARMACIST WANTED: Permanent part-time/full-time positions available. Raleigh area. Reply to Box XDL, c/o NCPhA, P.O. Box 151, Chapel Hill, NC 27514.

PHARMACISTS NEEDED: For Rite-Aid stores in Hickory, Boone, Asheboro and Wadesboro areas. For more information contact Jan Musten at (919) 789-4003.

PHARMACIST WANTED: Excellent opportunity to work in independent pharmacy. Top salary, competitive benefit package, good future. Reply to: Henderson Drug Company, 416 Dabney Drive, Henderson, NC 27536 or call (919) 438-6137 days/(919) 438-6328 nights.

PHARMACIST OPPORTUNITIES: Excellent environment in which to demonstrate professional skills. Positions available for the very best in many locations in the Carolinas. Excellent compensation and benefit programs including generous bonus and profit sharing. Join the leader in the Carolinas. Call Gary Judd at Eckerd Drugs, (704) 371-8242 to explore mutual interests.

PHARMACIST WANTED: Super X is now accepting applications for full-time RPh for openings in Asheboro, High Point and Danville, VA. Super X offers attractive salary, overtime premium and benefit package that includes continuous education, paid liability coverage, sick day compensation, paid life insurance and comprehensive medical coverage. For more information contact Neal

Johnson, 2810 University Parkway, Winston-Salem, NC 27104 or call (919) 777-0722.

PHARMACIST WANTED: We are an industry leader in the operations of community drug stores and are actively seeking full time professional pharmacists who are interested in a properous association with a growth oriented company. We have openings in Statesville, Rockingham, Fayetteville, Mt. Olive and Winston-Salem. We offer a complete benefit package including medical, dental, life and disability insurance, tax shelter profit sharing, savings program and continuing education. If you are looking for an association with a dynamic and expanding drug store chain call Recie Bomar at 800-444-4243. EOE.

PHARMACIST WANTED: Full time pharmacist position in community pharmacy and home health care center, located in northwest Washington state. Benefits and profit sharing program. If you enjoy the great outdoors; hiking, fishing, skiing, etc. contact Jim or Barb at (206) 452-4200 collect.

PHARMACIST WANTED: Position available with Raleigh area independent. Full-time. Excellent working conditions. Competitive salary and benefit package. Respond to: P.O. Box 41001, Raleigh, NC 27629.

RELIEF WORK

RELIEF PHARMACIST AVAILABLE: Central & Eastern North Carolina. Hospital or retail. Contact Pharmacy Relief, P.O. Box 2064, Chapel Hill, NC 27515 or call (919) 481-1272 evenings. Leave message.

NEED A PHARMACIST?: Pharmacist is looking for full-time or relief work in Charlotte area. Call after 7:30 p.m. (704) 553-1924.

RELIEF PHARMACIST AVAILABLE: Live in Chapel Hill. Will travel to any part of state. Retail and clinic experience. Please leave message. (919) 383-1421.

RELIEF PHARMACIST AVAILABLE: For weekend work in Central and Eastern North Carolina. Leave message (919) 485-4815.

FIXTURES FOR SALE

ANTIQUE STORE FIXTURES FOR SALE: Includes display cases, soda fountain, wall fixtures. Contact Charles Chapman at (704) 933-7775.

START YOUR OWN PHARMACY: Complete store fixtures & computer for sale. Building for rent. Location: Best in town. Call Kelly Terceira at (704) 894-8212 or write P.O. Box 368, Columbus, NC 28722.

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PHARMACIST OPPORTUNITY: Do you want to stand still as a chain pharmacist? Do you yearn to own your own drug store? Here is an opportunity for you! Coastal NC location, professional practice environment, nursing home provider, computerized pharmacies, option for part ownership. Call Don Heaton at (919) 453-8500 for an appointment to look.

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DOCTOR OF PHARMACY (PHARM.D.): Would you like to obtain a Pharm.D. degree? If you are a recent B.S. Pharmacy graduate, contact the Director of Admissions, Campbell University School of Pharmacy, Buies Creek, North Carolina 27506 or Call (919) 893-4111, Ext. 3101.

PHARMACIST: Pharmacist with 10 years experience in retail and industry. Masters degree in business. Interested in relocating approximately 6/89. Licensed in NC and VA. Interested parties reply to: Box GHC, c/o NCPhA, P.O. Box 151, Chapel Hill, NC 27514.

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MARCH 1989 VOLUME 69 NUMBER 3

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*Wiggins, Steven N. "The Cost of Developing a New Drug," Pharmaceutical Manufacturers Association, Washington, D.C., June 1987.

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EDITORIAL COMMENT

by Al Mebane

Good News and Bad

Like the man said, there's good news and bad. The good news is more pharmacists are now members of the North Carolina Pharmaceutical Association than ever before. Membership is up, dues revenue is up, participation is up, attendance at meetings is up and interest in general is up.

The bad news is more pharmacists than ever before are **not** members of the North Carolina Pharmaceutical Association. How can this be? Because of the influx of pharmacists into our fair state, and the number of new pharmacists licensed by examination who choose to remain in North Carolina, there are now more pharmacists licensed to practice than ever before in our history.

North Carolina is an exciting place to live and work. Pharmacy is an enviable profession because of the diversity of practice locations, practice options, practice specialties and the pay isn't bad either. There are opportunities still available in Pharmacy for persons to be employed in a job they enjoy and look forward to each day. There are opportunities for management, ownership, research and development, dialog and interaction with other professionals, challenges, successes, stroking, public approval and appreciation, travel, bonuses, perks and all the other attributes that job seekers put down on the line marked "why do you want this position?"

The North Carolina Pharmaceutical Association is a 109 year-old organization devoted to improving the economic and professional well-being of its members, through greater involvement in the delivery of health care and a larger presence in the view of the public and payors of health care services. How? By providing services that the members can not, or will not, provide for themselves. NCPhA members benefit from the programs and services of their state association. But, to some extent, so do non-members. By enhancing the image of members, NCPhA also enhances the image of non-members. Public perception is not selective. A pharmacist is a pharmacist.

Preaching to the choir does not bring in converts. Writing to you about association membership could be construed to be the same. But every pharmacist knows another pharmacist who doesn't join things, won't belong, doesn't feel the need to pay dues for something not immediately cost effective (or so it may seem). Almost every other (50%) pharmacist in North Carolina does not belong to NCPhA. Each has a reason or explanation. All have been asked to join by means of mailings.

Personal contact is the most effective means of communicating ideas yet developed. If you feel it is beneficial to you as a pharmacist or to the profession of pharmacy for you to belong to NCPhA, tell somebody who is not a member. Tell them what you view as your most valuable member benefit. It might persuade them to join.

NCPhA does not exist for its own glory, to boast of numbers and dollars. Yet numbers and dollars do matter in the eyes of persons in government and industry. As a noted student of politics recently said about letter writing to Congress, "Congressmen may not read every letter on a subject, but they certainly do count them." Pharmacy and NCPhA needs to stand up and be counted. If you want to have a positive impact on your profession, help add someone else to the membership role of the North Carolina Pharmaceutical Association. Encourage your fellow pharmacists to align themselves with organized pharmacy. For more information, call NCPhA on your toll free number—800-852-7343.

March, 1989

SCENES FROM THE PHARMACY LEADERS FORUM

NC Pharmacy Leaders Convene at the Fifth Annual Pharmacy Leaders Forum

The North Carolina Board of Pharmacy hosted the Fifth Annual Pharmacy Leaders' Forum at the Mid Pines Resort in Southern Pines, February 10-12, 1989. Approximately 38 pharmacy practitioners and educators attended the invitational meeting along with representatives from pharmaceutical manufacturers and wholesalers and chain drug stores. The purpose of the 1½ day forum was to discuss issues affecting the profession of pharmacy and to identify practical ways for advancing pharmacy in North Carolina. Evelyn P. Lloyd, President of the North Carolina Board of Pharmacy, presided.

Agenda

I. Report from the Task Force on Pharmacy Practice
II. Pharmacist Manpower Report
III. Third Party Payment Issues
IV. Catastrophic Health Insurance Act
V. Mail Order Prescriptions
VI. Health Care Consortium
VII. Campbell University School of Pharmacy Report
VIII. UNC School of Pharmacy Report
IX. Pharmacist Recovery Network (P.R.N.) Update
X. Definition of the Practice of Pharmacy
XI. Triplicate Prescriptions
XII. Fax Machines & Prescriptions
XIII. Standards for C.E. Programs
XIV. Supportive Personnel
XV. Foreign Graduates
XVI. Legislation

I. Report of the Task Force on Pharmacy Practice

Chairman Ronald W. Maddox reported on the findings of the Task Force on Pharmacy since the last Forum meeting in 1988. The Task Force, established by the Forum in 1987, has been investigating how consumers, physicians, and third party payers perceive pharmacists and pharmacy services. The overall objective of the Task Force is to identify what needs to be done to improve the pharmacist's image among North Carolina consumers with a goal of educating the public, other professionals and payers about the role of pharmacists in health care.

All three groups indicated that providing drug information and counseling on prescription and OTC products are the most important pharmacist services. More information regarding the conclusions of the Task Force will be forthcoming in state and national publications.

Task Force members include: Betty Dennis, Keith Elmore, Frances Gualtieri, Albert F. Lockamy, Jr., W. Keith Elmore, W. Whitaker Moose, William H. Randall, Christine Rudd, and Josiah R. Whitehead.

II. Pharmacist Manpower Report

Jan Hirsch Phillips, Ph.D., Assistant Professor of Pharmacy Administration in the UNC School of Pharmacy, reported on the results of a manpower survey commissioned by the Forum in 1988. The focus of the survey was to ascertain if there is a shortage of pharmacists in North Carolina relative to the number of pharmacy sites. Independent, chain and hospital pharmacy practice sites were included. Survey results indicated there is a shortage of pharmacists in NC, but it doesn't appear to be severe. The pharmacist shortage also varies according to locale throughout the state. Some counties have a higher vacancy rate relative to the number of practice sites, e.g., Richmond and Cumberland counties, whereas other counties, e.g., Durham, Wake and Orange counties, have a lower vacancy rate.

Dr. Phillips advised that additional study is needed to determine future trends and the effect of the pharmacist shortage on pharmacy services. She suggested this could best be achieved by compiling a database to help monitor pharmacist manpower in North Carolina.

The group was also reminded of the fact that North Carolina has more pharmacists per capita than the national average and is third in the nation in gaining pharmacists by reciprocity.

III. Third Party Payment Issues

Benny Ridout, Pharmacy Consultant for the NC Division of Medical Assistance, led much of the discussion on third party payment issues. Mr. Ridout cautioned the group that pharmacists have taken the risky strategy of accepting low fees from some third party payers while billing Medicaid higher fees. Pharmacists hurt pharmacy by accepting fees that are lower than what the federal government allows in the Medicaid program.

The use of AWP as the standard for drug reimbursement will continue to be an issue with

Continued on page 8

PHARMACY LEADERS CONVENE

Continued from page 7

third party payers and the federal government. Pharmacists have already seen reimbursement prices fall below AWP in some third party programs.

Mr. Ridout passed around a sample card from the Department of Human Resources that is now being issued to Medicaid recipients who are eligible for Medicare. Some pharmacists may think the beige-colored card is an authorization for Medicaid drug benefits; however, it does not involve the prescription drug program. Only the blue card from the Department of Human Resources identifies Medicaid recipients eligible for prescription drug benefits.

IV. Medicare Catastrophic Coverage Act

No changes are anticipated in the Medicare Catastrophic Coverage Act during this Congress. It is still not known if the government or individual pharmacies will pay for the processing charge estimated at $0.20 per prescription for the 700 million annual Medicare prescriptions covered by the proposed plan beginning January 1, 1991. At the present time, pharmacist reimbursement in the new plan is AWP plus a $4.50 dispensing fee, or usual and customary, whichever is lower.

A prevailing concern shared by those present was the uncertainty of what pharmacist manpower will be required to administer the plan. One participant also pointed out that the new plan will place additional strains on the federal budget as a presently cash paying and/or privately insured health care customer will be converted to the plan if they are >65 years of age and acquire drug expenses in excess of $600. Close surveillance of the Catastrophic Coverage Act will continue.

V. Mail Order Prescriptions

David Work, Executive Director of the NC Board of Pharmacy, showed the group a videotape on mail order pharmacies which was aired on *CBS This Morning*, February 8th and 9th, 1989. In the segment, Health Correspondent, Dr. Bob Arnot, presented the results of a several-week-long investigation conducted by CBS on mail order pharmacies. The focus of this investigation centered on National Rx Services, a mail order pharmacy in Las Vegas, Nevada, owned by Medco.

In 1988, the company was charged with manslaughter for the death of a woman in northern Idaho, due to a mix up in her prescription medication. The victim of the medication error, Iris Hemmelman, received Coumadin 5 mg instead of Prednisone 5 mg from the mail order pharmacy. She died in January 1988 of a massive acute cerebral hemorrhage as a result of Coumadin poisoning. The County Prosecutor who filed the cased said the mistake was made because of the company's high-speed, error-prone, assembly line operation.

Mail order pharmacies have become a billion dollar a year business in the last 4 years. Their popularity has grown because of their convenience and the cheaper prescription drugs they sell. Many, however, question the safety of mail order pharmacies and whether or not a true cost savings can be obtained, as some studies have indicated the contrary.

The videotape raised much discussion among forum participants. One participant emphasized that the mail order problem stems from pharmacists not helping the public to recognize the value of pharmacist interaction. The participant added that competition from physician dispensers is also a result of pharmacists' failure to impress upon the public the importance of pharmacy services. Another concluded that in order to maintain professional viability pharmacists must interact with their patients. The fact that there is a 25% illiteracy problem in NC further supports the need for more patient interaction.

IV. Health Care Consortium

Dr. William Edmondson, Vice President of Governmental Affairs/Professional Relations, Glaxo, Inc., presented the idea of organizing a Health Care Consortium composed of representatives from all sectors of health care in NC. The Consortium will be a forum for discussing topics of mutual concern and how to address them. "A proactive approach rather than a reactionary one is needed to address critical issues in health care, such as the Medicare Catastrophic Coverage Act," explained Dr. Edmondson. "The Consortium will provide a voice for North Carolina and carry a message to local and state legislators. We can make North Carolina a *litmus test state* for the nation," he added. Forum participants unanimously supported the concept. Albert Lockamy, A.H. Mebane, and Dr. Edmondson were charged with coordinating the organization of the Health Care Consortium group.

VII. Campbell University School of Pharmacy Report

Dean Ronald Maddox reported that 65 more students will enter the first year class in the fall of 1989, bringing the total school enrollment to 240. By July 1, 1989 the total number of faculty will reach 25. School officials are getting ready for another site visit from the A.C.P.E. team in preparation for the next step towards attaining accreditation.

Director of Admissions and Continuing Education, Daniel W. Teat, reported that this past year the school received 5 applicants per available position. The quality of applicants remains high as pre-pharmacy G.P.A.s averaged 3.25 on a 4.00 scale, well above the 2.75 national average. Eighty-two percent of the applicants were from NC.

The school's C.E. programs are also progressing; a home study A.C.P.E. approved C.E. course will soon be available from the school. Eleven different modules will comprise the home study course, including topics on hypertension, poisonings, and diabetes.

Thomas Wiser, Chairman of the Department of Pharmacy Practice, reported that the clerkship program for fifth year students has been approved by the Board of Pharmacy and is now is place.

VIII. UNC School of Pharmacy Report

Dean Tom S. Miya reported on his school's achievements of the past year: Students received the Undersecretary's award from the Health and Human Services for their work in organizing an effective AIDS awareness campaign. The students were awarded a $2500 scholarship for the School of Pharmacy. Consideration is now being given to expand the AIDS project nationally.

Abraham G. Hartzema, Ph.D. was awarded $565,000 by the Hartford Foundation to study medication prescribing habits and use patterns in rest homes.

This coming May the UNC School of Pharmacy will be hosting the American Chemical Society, the largest professional society in the nation, for a workshop in the school's Molecular Modeling Laboratory.

Associate Dean, Dr. George Cocolas, reported that pharmacy students have also been providing a Drug Abuse Education Program to elementary schools. Requests for the program have been overwhelming.

Dr. Cocolas also echoed Dr. Maddox regarding the exceptional quality of pharmacy school applicants. The UNC School receives twice the number of applicants per available position. Three-fourths of the applicants are from UNC. Five hundred twenty-five B.S. students are currently enrolled, which is approximately 170 students per class. Women comprise 68% of the school's total enrollment.

A new faculty member, William Johnston, Ph.D., has joined the Pharmacy Administration Department. Dr. Johnston's areas of expertise are: the delivery of services and the use of medications in mental health care; health care finance; and strategic management. He is also working closely with Dr. Phillips in the study of pharmacist manpower.

Betty Dennis, Director of Continuing Education reported that the School has been granted approved provider status for the maximum 6-year accreditation period following a recent A.C.P.E. review. She thanked all those who have dedicated their time and attention to the school's continuing education activities. Expanded curricular programs and teleconferences are planned for the future.

IX. Pharmacist Recovery Network (P.R.N.) Update

Dennis Moore, Director of the P.R.N., updated the forum on the status of the program. Currently, 11 pharmacists (3 females and 8 males) are receiving assistance from the volunteer program. Moore estimated that the problem of substance abuse afflicts about 350 pharmacists in NC. In order to reach these affected individuals, however, additional funds are needed to train and expand the volunteer base.

Moore plans to begin a statewide campaign to increase pharmacist and employer awareness of the program. Information about the P.R.N. program will be published in upcoming state publications.

The Pharmacist Recovery Network was established by NCPhA, NCSHP, and the Board of Pharmacy in August 1986. The goal of the P.R.N. program is to offer assistance to impaired pharmacists for a period of 30 months after the primary interface.

X. Definition of the Practice of Pharmacy

Fred Eckel, Chairman of the Pharmacy Practice in the UNC School of Pharmacy, presented the idea that the definition of pharmacy practice needs to be updated in terms of the year 2000. Mr. Eckel raised the questions, "Do we want to continue to convey the attitude that dispensing drugs is the heart of pharmacy or

Continued on page 10

PHARMACY LEADERS CONVENE

Continued from page 9

emphasize pharmacist-patient interaction, and other services, to insure the rational use of drugs?" He cautioned the group that automation, robotics, packaging innovations using bar code technology, advances in the mechanization of infusion devices, and the increased use of supportive personnel will totally revolutionize drug distribution.

Forum participants supported Mr. Eckel's idea and decided to formulate a committee to study the subject further. On a final note Mr. Eckel added that all segments of pharmacy should be represented in order to gain support for a new definition of pharmacy practice.

XI. Triplicate Prescriptions

The North Carolina Medical Society may ask to have a Triplicate Prescription bill introduced during the current NC legislative session based on recommendations from the Society's Pharmacy and Drug Abuse Committee.

If the Triplicate Prescription program were implemented, a prescriber would be required to obtain special triplicate prescription pads from a state agency which would administer the program (probably the State Bureau of Investigations, SBI). When a prescriber writes a prescription, a copy will be retained and two copies will be issued to the patient. The pharmacist, in turn, will receive both copies of the prescription from the patient, retain one for the pharmacy's records and mail the other to the SBI within a specified period of time.

Texas and New York currently utilize a Triplicate Prescription Program. The program was developed for the purpose of curtailing drug abuse via tighter controls of Schedule II prescription drugs.

The group's primary concerns were 1) the cost of implementing and administering such a program, as it appears to be costly to maintain in other states and 2) how prescriptions written by out-of-state prescribers would be handled since pharmacies routinely receive such prescriptions, particularly in cities along the NC borders. Activity surrounding this possible piece of legislation will be closely monitored.

XII. Fax Machines & Prescriptions

Forum participants discussed the increased use of fax machines in pharmacy settings to convey prescriptions. Participants expressed concern over the legalities surrounding the use of fax machines in community pharmacy practice. At the present time, the Board of Pharmacy is approving the use of fax machines in various practice settings on a case by case basis.

XIII. Standards for C.E. Programs

A representative of the Continuing Pharmaceutical Education (CPE) Review Panel expressed concern over approving some proposed C.E. programs. Only programs designed to improve pharmacists' ability to deliver pharmaceutical services will be considered by the CPE Review Panel. Organizations seeking approval of planned programs should follow the "Guidelines for Approval of CPE Programs" published in the February issue of *The Carolina Journal of Pharmacy*. Expanded guidelines will soon be issued by the CPE Review Committee.

XIV. Supportive Personnel

William Adams, Director of Pharmacy at Wilson Memorial Hospital, reported on new developments in pharmacy technician training and organization. A 9-month certification and diploma program is now available through the NC community college system. Technician training is still a top priority in institutional pharmacies as the Joint Commission on the Accreditation of Health Care Organizations standards mandate such. Several states require exam certification and licensure of pharmacy supportive personnel, e.g., Michigan. In December, a group of technicians in NC organized a local affiliate of the national Association of Pharmacy Technicians.

XV. Foreign Graduates

One participant shared a recent experience concerning a foreign pharmacist. Foreign pharmacists who have passed the NABP exam for foreign graduates and are available for work are unable to practice in North Carolina due to Statute 90-85.15 of the NC Pharmacy Practice Act. The Statute prohibits pharmacists from becoming licensed to practice pharmacy in NC who are not graduates of an accredited (U.S.) School of Pharmacy. Due to the pharmacist shortage in NC the Board of Pharmacy may want to consider changes in the statute.

A primary concern emphasized by group members was the need for foreign pharmacists to develop good language and communication skills before beginning pharmacy practice in the U.S.

XVI. Legislation

NCPhA lobbyist, Virgil McBride, reported on legislative activity since the General Assembly convened in January. Progress is slow; only two bills have been introduced and passed so far. Mr. McBride will continue to monitor legislative activity concerning pharmacy.

Forum Participants

Board of Pharmacy
David R. Work, Executive Director
Evelyn P. Lloyd, President
William R. Adams, Jr.
Harold V. Day
W. Whitaker Moose
William H. Randall, Jr.
William Biggers

UNC School of Pharmacy
Tom S. Miya, Dean
George H. Cocolas, Associate Dean
Betty Dennis
A. Wayne Pittman
John I. Mackowiak
Jan Hirsch Phillips
Steve Caiola

Chain Drug Industry
Jimmy S. Jackson, Kerr Drug Stores
Robert Myers, Eckerd Drugs

NC Division of Medical Assistance
C.B. "Benny" Ridout, Pharmacy Consultant

Pharmacist Recovery Network (P.R.N.)
Dennis Moore, Director

Campbell University School of Pharmacy
Ronald W. Maddox, Dean
Daniel W. Teat
Thomas H. Wiser

NCPhA
A.H. Mebane, III, Executive Driector
Albert F. Lockamy, Jr., President
Ralph H. Ashworth
R. Frank Burton, Jr.
Jack Watts
Robert Worley
Kathryn Kuhn Jefferson
Virgil McBride, lobbyist

NCSHP
Bruce R. Canaday, President
Fred M. Eckel, Executive Secretary
Pamela U. Joyner
Timothy Poe

NC Drug Wholesalers
W. Keith Elmore, Bellamy Drugs
C.R. "Rusty" Hamrich, Kendall Drug Company
Don Peterson, Mutual Drug Company

NC Pharmaceutical Manufacturers
William H. Edmondson, Glaxo, Inc.
Josiah R. Whitehead, Burroughs Wellcome Company

STATE BOARD OF PHARMACY

Members — W. R. Adams, Jr., Wilson; Harold V. Day, Spruce Pine; W. Whitaker Moose, Mount Pleasant; W. H. Randall, Lillington; Evelyn P. Lloyd, Hillsborough; William T. Biggers, Asheville; David R. Work, Executive Director, P.O. Box H, Carrboro, NC 27510.

Telephone # (919) 942-4454

RECIPROCITY CANDIDATES

Licensed as of 1/17/89

Charles G. Adams, GA

Leslie M. Addison, GA

Paul P. Antonie, WI

Bernard T. Box, KY

Morris B. Bray, SC

Patricia B. Buehner, OK

Michael A. Cannon, MT

Renae Kennedy Chadwick, SC

Ralph F. Cole, OH

Ana M. Cortes, IN

Joe A. Dalton, AL

Andrew J. Ehasz, SC

Jewel A. Freeman, WI

Walter J. Kelley, NY

Charles E. Krezmien, NY

Steve C. Mason, GA

Angel R. Morales, PR

Jesse F. Otto, III, OH

Jeffrey A. Patchett, IN

William H. Phillips, KY

Michael G. Prillaman, VA

Jimmie G. Raines, OH

Stephen B. Ruddy, PA

Francene Trainor, GA

Mark A. Umbarger, IL

Mary C. Fontenot, LA (as of 2/6/89)

NEW MAILING ADDRESS

The North Carolina Board of Pharmacy has a new mailing address:

P.O. Box 459
Carrboro, NC 27510-0459

Telephone 919/942-4454
(No Change)

AROUND THE STATE

In response to the recent Readers' Survey conducted by The Carolina Journal of Pharmacy, this column, featuring news around the state, has been resurrected from the past. The NCPhA staff welcomes your comments and any contributions you wish to make to this column. Photos are also welcome. Send us your news!

Awards, Honors, Citations

Congratulations to **Betty Dennis and the UNC School of Pharmacy** for receiving approved provider status from ACPE for the maximum 6 year accreditation period (January 1989–January 1995).

Appointments

Bruce R. Canady, Director of Pharmacy Services, Wilmington AHEC, was installed into the NCSHP office of President during the NCSHP Winter Meeting in High Point in February for the 1989–90 year. Other newly installed NCSHP officers include: President, **Timothy E. Poe**, Manager, Drug Information, Glaxo, Inc.; Treasurer, **William T. Sawyer**, Associate Professor, UNC School of Pharmacy; and Board Members, **Leslie R. Mackowiak**, Assistant Director of Pharmacy, Duke Medical Center and **Ronald H. Small**, Director of Pharmacy, NC Baptist Hospital, Winston-Salem.

NARD, the national association representing independent retail pharmacy, installed new officers for the 1988–89 year at its 90th Annual Convention in Atlanta, GA, October 9–13, 1988. **W. Whitaker Moose** of Mt. Pleasant was installed as Second Vice President. Mr. Moose also serves on the NC Board of Pharmacy.

Joe Miller of Boone has been appointed to the Governor's Task Force on Injury Prevention. The Task Force, headed by Dr. Thad Wester, Deputy State Health Director, was organized by Governor James Martin in December of 1988 to deal with the problem of sudden and unexpected injuries among North Carolinians. Injuries are the leading cause of death for North Carolinians under 44 years of age. The Task Force will be getting the message out to the citizens of North Carolina that "accidents do not just happen, they are caused."

Joseph A. Creech, Jr., of Creech Drug Co. in Selma, will serve as 1989 chairman of the Selma Merchants Committee. The Committee is an organization, composed of approximately 30 Selma merchants, business and professional people, for the purpose of promoting retail sales in Selma.

Henry L. Stewart of Pikeville was elected to chair the boards of Wayne Health Corp. and Wayne Memorial Hospital. Stewart, a registered pharmacist and owner of Pikeville Drug Store, is serving his second term on the board, which expires in January 1990.

In the News

Tom Hughes, Director of Pharmacy, NC Memorial Hospital, Chapel Hill, has recently resigned his position to become Director of Pharmacy at Brigham and Women's Hospital in Boston, Massachusetts.

Kathleen D'Achille, a long-term care pharmacist formerly from Clemmons, now living in Easley, S.C., and **William Edmondson**, Vice President, Government Affairs/Professional Relations, Glaxo Inc., are seeking election to serve 1989-1991 terms on the Board of Trustees of the American Pharmaceutical Association.

The Center for Disease Control has been awarded a new $565,000 grant to the **UNC Center for Health Promotion and Disease Prevention**. Monies will be used to develop model health promotion and disease prevention programs. The Center is a joint effort of the UNC Division of Health Affairs and the schools of dentistry, medicine, nursing, pharmacy and public health. It is one of five such centers in the country.

For the third year in a row, **Merck & Co.** has outscored 305 of the largest U.S. companies to be named *Fortune* magazine's most admired company. Merck ranked No. 1 in innovativeness, long-term investment, use of corporate assets, quality of management, quality of products or services and ability to attract and keep talented people. At its Wilson plant, the company manufactures all the Mevacor and Vasotec needed for sales in the U.S. A total of 15 dif-

Continued on page 14

Pam Corrigan of High Point, winner of the patient counseling competition sponsored by the Academy of Students of Pharmacy (ASP) at the UNC School of Pharmacy, will attend the APhA Annual Meeting in Anaheim, CA, April 8-12, to take part in the national competition. Burroughs Wellcome is helping support her trip. *Above:* Josiah Whitehead, Vice President of Corporate Affairs, Burroughs Wellcome, is presenting a check to ASP President, Kim Adams. Also pictured here are Dean Tom S. Miya, UNC School of Pharmacy and Pam Corrigan.

AROUND-THE-STATE

Continued from page 13

ferent drugs are manufactured and packaged in Wilson.

The Swedish pharmaceutical company, **Kabi** (recently shortened from KabiVitrum to improve its name recognition), is settling into a new $7 million building east of Clayton. The company makes a variety of intravenous nutritional products. Kabi's corporate office and research and development branches have also been relocated to the new facility.

MacKethan's Drugs has moved from its long-time location in downtown Fayetteville to occupy a new 5,000 square foot space at 2813 Fort Bragg Road. Historians say the drug store business was founded between 1901 and 1908. **David Underwood** is buying the business from his father, **Hamilton Underwood**, who has owned the family-run business since 1959. David, a graduate of Mercer School of Pharmacy in Atlanta, Georgia, moved back to Fayetteville in March of 1988 after practicing in Atlanta. His wife, **Ellen Underwood**, also a pharmacist, works at MacKethan's Drugs and teaches at Campbell University. MacKethan's Drugs has experienced a lively history, originally specializing in making home mixtures such as "violet toilet water" and "MacKethan's Baking Powder". The pharmacy still mixes a line of cough syrup, using a formula handed down from Hamilton Underwood's father.

Forbes Magazine recently rated the **Rite Aid Corp.** 120th out of over 900 companies ranked nationwide for profitability. Rite Aid is the nation's largest drug store chain, currently operating 2,160 stores in 22 eastern states.

The British drug manufacturer, **Beecham**, is looking at the Triangle and Charlotte as potential sites for a U.S. based research division that eventually would employ 500 people. If Beecham chooses NC, it would join a growing list of pharmaceutical companies with operations in this state. More than 30 drug companies employ about 11,500 people in NC — about 7,360 of them in the Triangle.

A pharmaceutical supplier, **Erytho Inc.**, from Santa Ana, CA is moving its headquarters to Johnston County where it plans to build a $7.5 million plant that eventually will employ about 150 people. Erytho produces "high tech" chemically engineered blood and plasma products used in manufacturing pharmaceutical products.

J.A. McNeill and Sons and Daughters, Druggists, has moved to a new larger location in Wilson Shopping Center after 87 years at its present downtown Wilmington location. Serving as pharmacists with their father, **John A. McNeill**, in the family-owned business, are **John A. "Sandy" McNeill, Jr.** and **Mary McNeill Hooks**.

Crime Reports

Break-ins: Royall Drug Co. in Elkin, a variety of controlled drugs were taken; Rite Aid Discount Pharmacy in Leland Shopping Center, Shallotte, $750 of schedule drugs were stolen; gunmen robbed Rite Aid Discount Pharmacy in Macon Plaza, Franklin, to obtain schedule II drugs; an armed man robbed the Revco Discount Drug Center in Lexington. Tussionex tablets and $115 were stolen. Drug Charges: A Dunn man was charged with 26 counts of obtaining Dilaudid, by fraud, from Kerr D.S. and The Medicine Shoppe in Dunn; and a Waynesville woman was charged with 12 counts of attempting to obtain anti-cough medicines by fraud from six pharmacies in the Asheville area.

Deaths

Sam C. Hall, Oxford, died Saturday, December 24, 1988, at age of 87. Hall graduated from the UNC School of Pharmacy in 1924 and operated Hall's Drug Store in Oxford for many years. He served on the Oxford Board of Commissioners and the Granville County Board of Commissioners.

Arthur R. Johnson, Winston-Salem, died February 2, 1989. He was 88 years old. Johnson was a 1941 UNC School of Pharmacy graduate. He moved to Winston-Salem in 1957 where he became Vice President of Flynn's Drug Store. He owned and operated the drug store for 12 years before retiring in 1985. Johnson was a member of NCPhA, the Forsyth Pharmaceutical Association and many community organizations.

Weddings

Sylvia Lynn Rose and Macon Scott Stanford exchanged wedding vows on October 15, 1988, in Holly Grove Advent Christian Church at Benson. The bride is a 1988 graduate of the UNC School of Pharmacy and is employed by Revco of Dunn. The couple is living in Benson.

Sarah Catherine McClure and Craig H. Wetter, both of Charlotte, were married December 31, 1988, at St. Mary's Chapel. The bride, a graduate of the UNC School of Pharmacy, is a pharmacist at Presbyterian Hospital. The couple will remain in Charlotte.

Amy F. Goulson and **Ben G. Cutrell** were married at 3 p.m. December 31, 1988 at United Church of Chapel Hill. Ben is a student at the UNC School of Pharmacy.

Births

Debbie Ritter Houston, class of 1978, and husband John, announce the birth of their second child, **Brent Parker**, on January 19, 1989. Debbie practices pharmacy at Greensboro Hospital.

Joseph Owen McDowell and Robin S. McDowell of Scotland Neck, announce the birth of their daughter, **Allison Joyner McDowell**. She was born on October 23, 1988, and weighed 9 lb. 5 ozs. Her father is a 1981 graduate of the UNC School of Pharmacy, and her paternal grandfather and great-grandfather are also UNC School of Pharmacy graduates.

Welcome, New Members!

Charles F. Brinkley, Hickory
Charles D. Cato, Durham
Nick Collias, Charlotte
Charlotte R. McCorkle, Granite Falls
Barry I. Siegel, Greensboro
Doris S. Totten, Belhaven
Mildred A. Underwood, Greensboro
Robert Keith Veeder, Raleigh
Ken Wallace, Asheville
Marc S. Drillings, West Lebanon, NH
Donald Ray Thrower, Gastonia
A.W. Benthall, Albemarle
Caroline Moss Lewis, Cullowhee
Joe A. Dalton, Raleigh
Jodi M. Dalton, Raleigh
Sheila W. Jones, Elizabeth City
Bryson Deal, Spartanburg, SC
John R. Ogburn, Newland
Elizabeth Hamilton, Winston-Salem
Edward R. Holder, Lillington
Charles E. Krezmien, Springville, NY
Livvie W. Vann, III, Burlington
Curt Coley, Kernersville
Roxanne Foster Salisbury, Apex
Bradley F. Narron, Wilmington
Joe Feutz, Asheville

AFFILIATE NEWS

Northwest Pharmacists' Association (NPA)

Two CE programs were scheduled for Association members in February: "Drug Product Selection" sponsored by Ayerst and "Home Diagnostic Products" given by guest speaker, Charles Pulliam. Another CE program, "Topical Rogaine Therapy" will be held on March 5, 1989, at the Babcock Auditorium at BGSM.

Since NPA was first formed 4 years ago, the Association has provided much to area pharmacists.

The social committee is planning an informal picnic for mid-April and a dinner club which will meet about once every other month.

For 1989, the officers and Executive Committee members are:

Officers

President ..... Terry Pace
1st Vice President ..... Karen Bryant
2nd Vice President ..... Phil Russ
Secretary ..... Lee Holland
Treasurer ..... Carol LaPonte

Executive Committee

Lori Tutterow
Martha Souther
Scott Morgan
Nancy Hardie
Chuck Buchanan

Moore County Pharmaceutical Association

The Moore County Pharmaceutical Association held their monthly meeting on February 14th at the JFR Barn in Southern Pines. Mr. Jim Paris was the honored guest for the evening. Jim has been a professional sales representative with A. H. Robins for thirty years. He will be retiring in March. Hal Reaves, Jr. commended Jim for his service and dedication to the pharmacy profession in Moore County. To show their appreciation, Jerry Rhodes, president of the Moore County Pharmaceutical Association, presented Jim with a certificate and some golf balls. Everyone expects him to soon have a handicap of 2!

Al Mebane was the guest speaker for the evening. He discussed the "Catastrophic" Medicare Program and how it would affect pharmacists in the future. We were pleased that Al took time out of his busy schedule to visit us in the Sandhills. Thanks Al!

Sarah Beale Cobb, Secretary
Moore County Pharmaceutical Association

Wake County Pharmaceutical Association

Approximately 75 pharmacists and manufacturing representatives attended the Feburary 7, 1989 meeting at Ballentine's Restaurant. All

Left to right: Jim Stewart, V. Pres., Jerry Rhodes, Pres., Jim Paris, Jim Heinz, Treas., & Bob Beddingfield, Past Pres.

enjoyed the fellowship of their colleagues and a very interesting program on "Drug Product Selection" given by Betty Dennis of the UNC School of Pharmacy. The program was sponsored by Wyeth-Ayerst Labs.

The next meeting will be held in conjunction with the Wake County Dental Society at the Wake AHEC Auditorium in Wake Medical Center, Raleigh. Dr. Timothy Ives, Assistant Professor, Department of Family Medicine, UNC School of Medicine, will conduct the program, "Update In Antibiotic Therapy for Dentists and Pharmactists."

COMMUNITY PROJECT: The Medication Manager

Submitted by Jane S. Thompson, R.Ph., Project Coordinator, The Medication Manager

Jane S. Thompson, consultant pharmacist for SupeRx Nursing Home Operations in Winston-Salem, has been appointed as project coordinator of a drug education program for the community's older adults. The Medication Manager Project is funded by The Winston-Salem Foundation, The Baptist Retirement Homes, and SupeRx Drugs. Monthly workshops have been scheduled for 1989 through September. Plans are being made for a Drug Information/Health Fair in October 1989—which will involve cholesterol and blood glucose screening, blood pressure monitoring, and drug/health information booths. The adult over 65 years of age can benefit tremendously from the workshops, at which an abundance of patient education materials and information is presented. The workshop participants are encouraged to become actively involved in their own health care by becoming successful "medication managers" themselves.

Workshop participants receive individualized folder-packets which contain specific information concerning the medications that they are currently taking, based on completion of a registration form two weeks prior to the scheduled workshop. This completed form is used as the base for a "mini" drug regimen review by a consultant pharmacist, who screens for drug interactions and offers comments or suggestions for appropriate drug use. Corresponding USP Drug Education Leaflets are added to the folder-packets, as well as other health and drug information and educational materials. Much of the material used is provided by drug manufacturing companies, professional pharmacy associations, government agencies, and geriatric teaching institutions.

At this point in time, the Medication Manager Project is a local effort and contained within Forsyth County. However, it is hoped that, with increased public knowledge and support from pharmacy organizations, this project will expand beyond the one year of funding and grow to state-wide proportions. The need is there. Only 5% of the nation's elderly live in nursing homes. The remaining 95% are still living independent lives, many of them in residential facilities. It has been determined that 30% of older adults make medication errors that may have serious clinical consequences; and 30% of those over 65 who take prescription drugs say that they do not know enough about their medications—what they are and how they are likely to help them.

There are over 30,000 people over 65 years of age in Forsyth County. It is the goal of this project to reach as many of them as possible in 1989 and promote appropriate medication use by increasing the sources of drug information and improving the level of drug knowledge in the community's older adults.

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THE NORTH CAROLINA PHARMACEUTICAL ASSOCIATION BEACH CONVENTION VACATION

North Myrtle Beach Hilton, South Carolina
109th Annual Convention
May 17-21, 1989
Convention-in-Brief

Wednesday, May 17

3:00 p.m.-6:00 p.m.	Registration *Main Lobby*
6:00 p.m.	PRESIDENTS' RECEPTION honoring the Presidents of NCPhA, the Woman's Auxiliary & the Traveling Member's Auxiliary *Pool Terrace*
7:00 p.m.	*OPENING SESSION BANQUET — Master of Ceremonies, President Al Lockamy, Jr.; featured speaker, Robert H. Henry presenting, "Win With A.C.E.S., Attitude & Ambition, Commitment, Enthusiasm and Service" followed by Award presentations *Center Ballroom*

Thursday, May 18

7:00 a.m.	Woman's Auxiliary Beach Walk-A-Thon (Everyone is invited to participate.)
7:30 a.m.	T.M.A. Foundation Auxiliary Breakfast *Staff Conference Room*
7:30 a.m.	V.I.P. Breakfast *West Ballroom*
8:00 a.m.-1:00 p.m.	Registration *Main Lobby*
9:00 a.m.	**1st NCPhA BUSINESS SESSION — President-Elect, Ralph H. Ashworth, presiding. Rite of the Roses conducted by Third Vice President, Mr. Robert W. Worley and Mrs. Robert W. Worley; President's Address; Schools of Pharmacy Reports; CE Program: "Legal Issues Associated With Expanded Roles For Pharmacists With Regard To Patient Services" presented by Walter Fitzgerald, J.D., Executive Director and General Counsel, American College of Apothecaries *East Ballroom*
10:30 a.m.	Woman's Auxiliary Brunch and Fashion Show by Myrtle Beach's *Victoria's Ragpatch.* **Sponsored by Glaxo, Inc.** *South Deck*
12:30 p.m.	Campbell University and UNC Schools of Pharmacy Preceptors' Luncheon *Parlours I-IV*
12:30 p.m.	Woman's Auxiliary Shopping Spree at Pawley's Island
1:00 p.m.	GOLF & TENNIS TOURNAMENTS — **Golf sponsored by Owens Brockway, Co-Chairmen, Junior Little & Mike Joyner; Carts by Burroughs Wellcome Co.; Tennis sponsored by Jefferson Pilot, Co-Chairmen, G.N. (Jerry) Brunson & Sam Stuart**
9:00 p.m.-midnight	T.M.A. Dance featuring *THE EMBERS*; cash bar. **Sponsored by the Traveling Member's Auxiliary** *Center Ballroom*

Friday, May 19

7:00 a.m.	*PharmPAC Breakfast (Everyone is welcome.) *Alfredo's*
8:00 a.m.-1:00 p.m.	Registration *Main Lobby*

8:30 a.m.	Woman's Auxiliary Coffee *Hospitality Room 402*
9:00 a.m.	**2nd NCPhA BUSINESS SESSION — Second Vice President, J. Frank Burton, Jr., presiding. CE DAY, Program 1: Cholesterol Education Program by Kirk Ways, M.D., East Carolina School of Medicine, Department of Endocrinology. Program 2: "Managing Your Pharmacy's Financial Health" by Jean P. Gagnon, Ph.D., Director of Pharmacy Relations, Marion Laboratories *East Ballroom*
9:30 a.m.	Woman's Auxiliary Business Session *West Ballroom*
11:00 a.m.	Traveling Member's Auxiliary Business Session *Parlours I-IV*
12:00 p.m.	Woman's Auxiliary Luncheon featuring *The First Resort*, A Sweet Adelines Barbershop Quartet. **Sponsored by Burroughs Wellcome Co.** Installation of Officers will follow the luncheon. *Another World*
12:00 p.m-1:00 p.m.	Complimentary lunch for Exhibitors in *The Exhibit Hall*
1:00 p.m.-6:00 p.m.	EXHIBITORS FAIR AND LUNCHEON *The Exhibit Hall*
11:00 p.m.	ICE BOX RAID/DESSERT RECEPTION *Pool Terrace*

Saturday, May 20

7:30 a.m.	*1939 Class Reunion Breakfast *Parlours I-IV*
7:30 a.m.	*Christian Pharmacists' Breakfast *Another World*
8:00 a.m.-12:30 p.m.	Registration *Main Lobby*
9:00 a.m.	**3rd NCPhA BUSINESS SESSION — President Al Lockamy, Jr., presiding. Annual Salary Survey presented by Jan Phillips, Ph.D.; NCPhA Committee Reports; Nominations of NCPhA 1990-91 Officers; Executive Director's Report *East Ballroom*
12:30 p.m.	*RECOGNITION LUNCHEON Installation of Officers, Luncheon, 50-Plus Club Inductions and Awards *Center Ballroom*
2:30 p.m.-5:00 p.m.	Academy of Consulting Pharmacists — moderator, Charles Pulliam *Parlours I-IV*
7:00 p.m.	*A NIGHT IN THE ISLANDS featuring a Luau feast and the *Lei Aloha's Polynesian Rainbow Revue Pool Terrace & Deck*

Sunday, May 21

8:00 a.m.	Seminar Registration
9:00 a.m.-3:00 p.m.	SEMINAR: THE PHARMACIST'S ROLE & RESPONSIBILITY IN HEALTH PROMOTION AND DISEASE PREVENTION —Sponsored by NCPhA and NCSHP. Background information on cancer screening and substance abuse recognition and prevention and "how-to" programs for use in your community will be presented. Six contact hours of A.C.P.E. Continuing Education will be provided. Look for details of the seminar program in the mail.

**Reservations for these activities may be purchased through the NCPhA office.*
***All convention registrants are invited to NCPhA's Business Sessions.*

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Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.
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• Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
• Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.
Adverse Reactions: (percentage of patients)
Therapy-related adverse reactions are uncommon. Those reported include:
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• Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
• Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, and serum-sickness-like reactions that have included erythema multiforme [rarely, Stevens-Johnson syndrome] and toxic epidermal necrolysis or the above skin manifestations accompanied by arthritis/arthralgia, and frequently, fever): 1.5%, usually subside within a few days after cessation of therapy. Serum-sickness-like reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.
• Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
• As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
• Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.
• Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%; and, rarely, thrombocytopenia.
Abnormalities in laboratory results of uncertain etiology:
• Slight elevations in hepatic enzymes.
• Transient fluctuations in leukocyte count (especially in infants and children).
• Abnormal urinalysis, elevations in BUN or serum creatinine.
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PharmaDates

1989

April 8-12—APhA Annual Meeting, Anaheim, CA

April 16—NCPhA Mental Health Committee Meeting, Institute of Pharmacy

April 16—NCPhA Consolidated Loan Fund Committee Meeting, Institute of Pharmacy

April 18—Board of Pharmacy Meeting, Board of Pharmacy

April 26—NCPhA Nominating Committee Meeting, Institute of Pharmacy

May 1-2—NARD 21st Annual Conference on National Legislation & Public Affairs, Washington, D.C.

May 4-5—NCPhA National Legislative Committee Meeting, Institute of Pharmacy

May 15—Board of Pharmacy Reciprocity Examination, The Carolina Inn

May 16—Board of Pharmacy Meeting, Board of Pharmacy

May 17-20—NCPhA Annual Convention, North Myrtle Beach, SC

May 21—*NCPhA/NCSHP Seminar, North Myrtle Beach, SC

June 4-8—ASHP Annual Meeting, Nashville, TN

June 20—Board of Pharmacy Meeting, Board of Pharmacy

June 26-27—Board of Pharmacy Licensure Examination, UNC School of Pharmacy

July 17—Board of Pharmacy Reciprocity Examination, Institute of Pharmacy

July 18—Board of Pharmacy Meeting, Board of Pharmacy

August 15—Board of Pharmacy Meeting, Board of Pharmacy

September 18—Board of Pharmacy Reciprocity Examination, Institute of Pharmacy

September 19—Board of Pharmacy Meeting Board of Pharmacy

September 20-21—NCSHP Fall Seminar, Greensboro

October 17—Board of Pharmacy Meeting, Board of Pharmacy

December—ASHP Midyear Clinical Meeting, Atlanta, Georgia

**Note: The NCPhA/NCSHP Seminar was previously scheduled on Wednesday, May 17, 1989. It has been changed to Sunday, May 21, 1989.*

Letter to the Editor

The Editor
North Carolina Pharmaceutical Association
P.O. Box 968
Chapel Hill, NC 27514

Dear Sir:

Each year, as part of the orientation course that Jan Phillips and I teach to the new pharmacy students at the University of North Carolina, students are required to visit a pharmacy practice site and discuss the profession with a practioner. I continue to be overwhelmed by the willingness of our pharmacists in North Carolina to make themselves available so readily to these budding pharmacists. Because so many pharmacists participate in this program it is impossible for me to thank you individually. Therefore, I wanted to express my appreciation to North Carolina pharmacists, in general, for their overall support of our School's educational program and, in particular, their willingness to participate with our students in this project. Each year, as I read 170 reports, my sense of pride in North Carolina pharmacy practice is reinforced. Almost universally these students receive a positive exposure to the joys of our profession. For many students this represents their initial exposure to pharmacy practice and it reinforces for them their career choice. Other students use it as an opportunity to explore other facets of pharmacy practice to which they have not been exposed. They find new perspectives about pharmacy career opportunities. Universally, students have found this exercise to be a worthwhile experience. Your willingness to share yourself with the students, as well as your positive views about pharmacy as a profession is the reason this exercise works so well. Our profession is in good hands because our practitioners are serving the people of North Carolina so well.

Sincerely,
Fred M. Eckel, M.S.
Professor of Hospital Pharmacy and
Chairman of the Division of Pharmacy Practice
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Managing Professionals

This is the fourth in a series of articles for professionals who manage and managers who lead professionals and those who are both. Pharmacists operate with one license, but fill many different professional roles in hospitals, chain stores, individual stores, drug companies and universities. Along the way they need a broad variety of management skills. These articles take a broad perspective on management concepts we hope you will be comfortable applying.

Curtis P. McLaughlin

In the last article we looked at how professions develop and maintain their status. Your basic job is managing the members of a profession—something I have heard compared to "herding cats" or "herding quail." What are the keys to managing professionals? The first is understanding them. They are of above average intelligence and achievement, well-educated, and expect to be recognized as such. They often have greater technical knowledge in their field than those who supervise them (either nonprofessional managers or older professionals). They believe that they deserve and require greater autonomy than the run-of-mill employee. They have job mobility—the better the individual, the greater the mobility—so the best ones can vote early and often with their feet. They are self-evaluating (internally and by peers). They tend to be more attuned to the values of their profession than to the organization that pays them.

How then do you manage them? Unfortunately, their expectations can be unrealistic. Often the product of privilege, often bolstered, used to succeeding, they have high career expectations. What do we offer? A white coat and a high starting salary. Yet what sometimes comes with it? A limited, shallow career ladder. Shift work. A boundary role that is draining, aggravating and often misunderstood. The Peggy Lee song—"Is That All There Is?"—by 40? By the way, where do old pharmacists go to? No wonder we often see burnout and disillusionment.

The key to managing professionals rests with managing expectations. If their expectations, often unrealistic to start with, are not managed, they will leave your company, store or hospital. You know that the first law of marketing for services is that quality to the customer is the difference between experience and expectation. In services there is the additional challenge called "internal marketing"—marketing to your own staff to align their behaviors and expectations to those of your oganization. Your internal marketing involves presenting to your professional employees a realistic set of expectations about the current job and future jobs in your organization.

The place to start is to manage the joining-up process carefully, making sure that you do not overrate the situation just to get warm bodies on board. If you have high turnover, take a good look at what you are promising. Is it close to what the job is really like? If people find that the job comes in under expectations, they get mad and leave. If it comes in too far above expectations, they get anxious—they begin to wait for the other shoe to drop, because they fear that they are going to have to pay for their good fortune sooner or later. For high-stress or low-satisfaction jobs the best policy is "What you see is what you get." That goes beyond being honest. Research indi-

Continued on page 25

CURTIS P. MCLAUGHLIN is a Professor of Business Administration in the School of Business and Professor of Health Policy and Administration in the School of Public Health at the University of North Carolina at Chapel Hill. McLaughlin received his masters and doctorate degrees in Business Administration from Harvard Business School. He has written numerous management articles for a variety of publications, including Harvard Business Review, and has consulted for domestic and international corporations. Some of his professional interests include the production of professional services in research, engineering, medicine, public health and education; management of not-for-profit organizations; and productivity improvement.

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MANAGING PROFESSIONALS

Continued from page 23

cates that it means giving the recruit a chance to experience the real job atmosphere—warts and all. When the employer does that, those who still choose to come on board stay longer and are more satisfied. We will look more closely at the joining-up process next time.

Recruitment and selection and utilization can go a long way to help alleviate burnout. There are people—extroverted personality types—who thrive on dealing with people. There are those with introverted personality types who are drained by interacting with people all the time. You cannot tell one from the other by verbal skills or appearance. Unless you use a psychological test like the Myers-Briggs test for evaluation, the best clue is how people spend their leisure time on or off the job.

Your organization may need both types. If you manage a hospital pharmacy service, you will find that the extroverts will love the consults and patient education role, but perform badly if kept too long in the back room. The introverts will be much more happy and more effective with larger doses of work in the back room.

This does not mean to say that you pigeon-hole the two types. All of us are a mixture of the two and research shows that one of the best ways to avoid burnout is to have people switch off from frontline roles to backroom roles within a given working day. It is a matter of degree.

The third step is to make sure that a significant proportion of their work is meaningful. Not every minute of it. Even the presidents of major corporations spend a lot of time doing ceremonial things that don't use their full potential, but the rest of the time makes up for it. The professional employee needs to understand the set of tasks that make up the job and how much of their time, if any, is devoted to the technological forefront.

The smaller the organization, the harder it can be to maintain a high level of professionally meaningful work. People cannot specialize, they must pitch in and do a little of everything. The small store offers the pharmacist a chance to get to see the whole picture and that leads to a high initial level of interest, but it can pale very rapidly. Six months to someone in their twenties seems like a lifetime, and all too often I hear former students saying "I've been in that job nine months and I've learned everything I can from it. It's time to move on to something else."

If you want to hold good young professionals, you have to be able to give them ever-increasing responsibilities and you have to lay out that path in front of them. If you cannot, then you have two choices—1) go with the second-best type of employee, or 2) continue to hire the best, but take it as a given that they will turn over. Turnover can be costly, but for some jobs and some places it is a natural way of life.

The fourth step is to work hard at the task of motivating them to continue to work effectively and to stay current. This also will be the topic of another article in this series.

You must start with the fact that each professional operates at least three levels of goals. They have individual goals, they have professional goals, and they are also factoring in your organizational goals. You cannot succeed just by harping on the latter. You have to understand the first two as well and design the situation so that the whole set is enhanced. In essence, any negotiation with a professional leads to a compromise solution—a compromise which supports all three levels of goals—but not necessarily one that squares as well with corporate objectives management would like. Mediating corporate and personal goals is normal for effective managers. It is the addition of that third, professional set of objectives that often buffaloes experienced managers.

You would expect such a problem between non-technical managers and professionals. It is usually a serious problem when a person from one profession supervises one from another. Yet it should not be a problem when supervisor and professional are both members of the same profession, or should it? Sometimes it is, because the primary source of professional indoctrination is the professional school and schools do not necessarily have the same definitions of professional behavior. Perhaps even more problematic is the fact that professional schools change over time and what was right at one time may no longer be accepted practice. In rapidly changing fields a generation gap is far less than twenty years.

You can avoid this latter pitfall by asking the newcomer about his or her professional values and training rather than assuming that it will match yours. If someone who is otherwise well-qualified does something that goes against your training, don't get parental about it. Ask them why? You might even learn something. At the very least you have avoided a threat to that person's professional identity that could have been a powerful demotivator to them.

then these four rules of managing professionals;

1. Manage their expectations carefully.
2. Manage the joining-up process.
3. Give them enough work that is meaningful.
4. Work at motivating them to work and to stay current.

Masters Degree Programs For Working Health Professionals Starting in Charlotte in August

The University of North Carolina at Chapel Hill is accepting applications for its twelfth off-campus Master of Public Health program to begin August 1989 in Charlotte.

The program is offered by the UNC-CH School of Public Health and is co-sponsored by the Charlotte, Northwest, Mountain, Greensboro and Fayetteville Area Health Education Centers. It offers persons in western North Carolina an opportunity to receive graduate training in health administration or public health nursing (subject to approval), while continuing to work full time.

The programs require 36-39 credit hours for graduation (12-13 courses). Approximately 10 of these courses will be taught at the AHEC Center in Charlotte. The remaining coursework will be offered either on weekends, or as independent guided study modules. Courses taught in these formats will require students to attend classes on the Chapel Hill campus for two day periods up to four times a semester. Public health nursing students will have field placements arranged to meet individual needs.

Students should meet the following academic requirements for admission:

1. Bachelor's or higher degree from an accredited college or university;
2. Grade point average of 3.0 or better in the *major* subject;
3. Score of 1,000 on the combined verbal and quantitative parts of the Graduate Records Examination (GRE).

In addition, each program has requirements related to professional experience. Applicants for the program in health administration must have worked in a responsible clinical or administrative position in a health or human service organization for at least three years at the time of admission, and should have long-term goals in health and human services administration.

The Program in public health nursing is designed for those individuals who are specifically interested in public health nursing administration and supervision. Applicants for this program should have a minimum of one year of experience as a graduate nurse (preferably in a community setting, or field related to public health nursing practice), be a licensed registered nurse, and be professionally employed.

Interested persons are urged to begin the application process as soon as possible. Experience has shown that it may take as long as 3 months before all college transcripts, GRE scores and recommendations are available to the admissions committees. Applicants who do not have a current GRE score are encouraged to register for the exam at the earliest opportunity. This examination is administered statewide on April 8th and June 6th.

For information and applications write or call:
Office of Non-Residential Programs
Department of Health Policy & Administration
CB #7400, 263 Rosenau Hall, School of Public Health
Chapel Hill, N.C. 27599-7400
(919) 966-1451

or

Registrar in the Curriculum in Public Health Nursing
CB #7400, 333 Rosenau Hall, School of Public Health
Chapel Hill, N.C. 27599-7400
(919) 966-1069

DRUG COSTS

An article appearing in the February 1989 issue of *American Druggist* indicated that medications dispensed by pharmacists account for only about 5 cents of every dollar spent on health care. In fact, the cost of medications, as a percentage of total health care costs, has been going down. On the other hand, the cost to develop each new drug that is found sufficiently safe and effective to be used by the American public has topped $125 million.

FDA SAFETY ALERT:
Homemade Saline Solutions
For Contact Lenses

This is to ask your help in alerting patients to the hazards of improperly using homemade saline solutions in caring for contact lenses. Although you might not recommend the use of homemade saline solutions, some of your patients may be using them despite your recommendations. These patients need to know that improper use can result in serious infections that could cause blindness.

Problem

A recent increase in reported infections among soft contact lens wearers has elevated the concern of the ophthalmic community and the Food and Drug Administration (FDA).

Homemade saline solutions, generally prepared by dissolving salt tablets or capsules in distilled water, are non-sterile and may be contaminated with pathogenic microorganisms such as bacteria and *Acanthamoeba*. These solutions can be safely used in the heat disinfection of contact lenses because the high temperatures are sufficient to kill the organisms.

But if homemade saline solutions are used improperly—that is, as a rinse or eyedrop AFTER heat disinfection, or with chemical disinfection of the lenses—serious infections can result. (It has been shown that some chemical disinfection systems do not kill certain species of *Acanthamoeba*.) In July 1987, the Centers for Disease Control reported on a case-control study that showed an association between the use of homemade saline solutions and *Acanthamoeba* infections (JAMA, July 3, 1987, pp. 57-60). Although this infection represents only a small proportion of all ocular infections, it is a very painful and debilitating condition that is difficult to treat and may lead to blindness.

Recommendations

To address this problem, FDA is requesting stronger warnings on salt tablet and salt capsule containers. But we also need your help in changing patient behavior. We are asking that you convey these important warnings to your patients:

- Use homemade saline solutions only BEFORE or DURING HEAT disinfection.
- Never use AFTER heat disinfection.
- Never use with CHEMICAL or hydrogen peroxide disinfection.
- Never use in the eye or as a wetting solution.
- Prepare fresh saline solution daily.
- Sterilize solution bottle with boiling water at least once a week.

Thank you for your help in this important effort. If you have comments or questions please contact Richard E. Lippman, O.D., F.A.A.O., Director of our Division of Ophthalmic Devices at 8757 Georgia Avenue, Room 440, HFZ-460, Silver Spring, MD 20910.

CONGRATULATIONS TO

JEFF STILLWAGON and NED GRIFFIN

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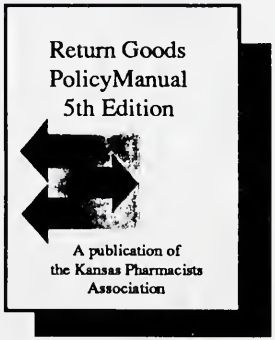

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DICKINSON'S PHARMACY

An FDA role in mail Rxs? The October dismissal of the Iris Hemmelman manslaughter case against the country's largest mail-order drug company *(State of Idaho v. National Rx Services, Inc. a/k/a Medco)* has raised a complex set of major issues in pharmacy.

As explained by Latah County Prosecutor Craig Mosman, the dismissal was based on the inability of the county (and perhaps by extension, also the state) to fund the bitterly contested case through years of courtroom wrangling and possible appeals.

Among assurances given the state by Medco was its promise to abide by the findings of a Nevada Board of Pharmacy "human factors" study of the stress-error ratios in the company's Las Vegas facility.

At the time of this writing, the results of that study were not public, but I am reliably informed that it showed departures from sound "human factors" principles.

"Human factors" engineering is a relatively new science that owes its origins to a syndrome first noticed during World War II, when the most-experienced bomber pilots began crashing on take-off more frequently than rookies. The only difference before and after the crashes started happening was a model change in the kind of aircraft flown, wherein the undercarriage-retract lever above the pilot's head was relocated slightly.

The old pros were used to groping instinctively, with flawless accuracy, for the lever in the old model, but the young rookies had no such instincts, and always looked visually for the lever.

Because of the intense time pressure of war-time take-offs — the faster the undercarriage was retracted, the quicker the take-off, the sooner the mission was over, the more missions you could fly in a day — these few split-seconds were enough to cause crashes.

The discovery of this syndrome in the mind's complex relationship to time and the manipulation of close objects was the birth of "human factors" engineering.

Pharmacy, of course does not use "human factors" engineers. But, as mail-order pharmacy and some high-volume hospital and chain pharmacies are demonstrating, assembling-line time-and-function pressures may require it. Indeed, the National Association of Boards of Pharmacy is deep into a study of just this question.

James G. Dickinson

In view of the Hemmelman death and other incidents, I decided not to wait for all this to transpire. In October, I filed a 100-page citizen's petition with the Food and Drug Administration, asking it to exercise its prerogative to regulate mail-order pharmacies under federal good-manufacturing practices regulations.

I did this under two premises — first, since mail-order facilities routinely break up prescriptions into different functions by different people and reassemble them at the end of the line, they are not pharmacies *per se*, but repackagers — and second, since state efforts to address this will be piecemeal and slow, avoidable injuries will occur unless a national standard is quickly imposed.

That national standard already exists in FDA good manufacturing practices regulations that require in-process quality assurance controls, known as "process validation."

In other words, the split-up and dispersed separate aspects of dispensing in mail-order pharmacies could not be performed unless each step was separately validated by an in-house Quality Assurance unit, and the reassembly of the

Continued on page 30

James G. Dickinson . . . Who is this mystery man? Mr. Dickinson's column, Dickinson's Pharmacy, has been running in our journal for the last two years. His column is syndicated and appears monthly in many state pharmaceutical journals across the country. Mr. Dickinson is also editor and publisher of Dickinson's FDA and Dickinson's PSAO industry newsletters. He has served as assistant executive director of the American Pharmaceutical Association and Washington bureau chief for Drug Topics. His home is in Morgantown, West Virginia.

DICKINSON'S PHARMACY

Continued from page 29

prescription at the end of the line similarly would have to be validated. And each act would have to be documented in a paper trail verifiable by FDA inspectors in biennial inspections. Obviously, this would slow down 20-prescriptions-plus-per-hour assembly lines all over the country.

I have discussed my petition with various regulatory pharmacists and do not find much enthusiasm for it.

First, there is skepticism that Iris Hemmelman's death is the tip of an iceberg at all, despite other mishaps that were not fatal. "Just an isolated, terrible tragedy," as Medco itself puts it.

Second, there is a feeling that to federalize the problem is to go against the tide of this entire decade — regulatory decentralization. Leave it to the states.

Third, there is disagreement that mail-order pharmacy is more "repackaging" than it is pharmacy to begin with. The future employment of pharmacists is felt to be trending to the high-volume facility, whether mail-order, hospital, or retail.

Mail-order is the wave of the future, and the profession of pharmacy had better get (and keep) a handle on it, some feel.

Anyone who has followed "Dickinson's Pharmacy" knows I do not buy that. I am for high-tech, high-touch personalized pharmacy for everyone, except where hardship requires inferior alternatives. High-volume, assembly-line dispensing is simply not my idea of a professional activity — it is technician work, like assembling an automobile in Detroit, you can get robots to do it.

The only judicial ruling that bears on this that I am aware of is *United States v. Sene X Eleemosynary Corp.* (479 Fed.Supp. 970 [S.D. Fla. 1979]), which was about a pharmacy that tried to escape FDA regulation of its topical procaine compounding operations, under the ruse of these being protected as "the practice of pharmacy."

In asserting that pharmacies are not exempt from FDA good manufacturing practices and other regulations, the court went to the trouble of saying what a genuine "pharmacy" is.

One characteristic of a true pharmacy is that the pharmacist has a one-on-one relationship with the pharmacy's patients — "a customary characteristic in the usual practice of pharmacy." Another characteristic is that the prescriptions dispensed in a true pharmacy are "written by physicians who are known" to the pharmacist. And a third character is that the bulk of a true pharmacy's prescriptions are not received from out of the state in which it is located.

The court's opinion is written loosely, but the point is surely made that *knowing* the prescriber and/or *knowing* the patient is legally important.

Conventional hospital and chain pharmacies of whatever prescription volume can probably satisfy one of those two criteria, if not both. No high-volume mail-order pharmacy can satisfy either, simply because of the logistical realities of interstate commerce.

And "interstate commerce" is the statutory threshold through which FDA regulation over *anything* is enabled. If you wish to add your comments to FDA's consideration of my petition, you may write to Dockets No. 88P-0367, Dockets Management Branch, FDA, 5600 Fishers Lane, Rockville, MD 20857.

This feature is presented on a grant from G.D. Searle & Co., in the interests of promoting the open discussion of professional issues in pharmacy. G.D. Searle & Co. accepts no responsibility for the views expressed herein as they are those of the author and not necessarily those of G.D. Searle & Co.

"Make Your Voice Heard" Available

The American Pharmaceutical Association has published a government affairs brochure entitled "Make Your Voice Heard."

This is a concise 32-page booklet which explains various methods of interacting with legislators at the Federal and state levels. The booklet tells when to telephone, what to say, when to write, how to arrange face-to-face meetings, and how to work with state and national associations. The path of legislation, examples of how individual pharmacists influence their representatives, often-used Washington phone numbers, and a guide to obtaining Federal legislative documents are also included.

A free copy of the booklet will be mailed to all NCPhA members in the upcoming months. Nonmembers of NCPhA may order the booklet directly from APhA by calling (800) 237-2742. The price of the booklet is $3.00 for APhA members or $5.00 for nonmembers. "Make Your Voice Heard" is a collaborative effort between APhA and Glaxo, Inc.

CORRESPONDENCE COURSE
The Art of Patient Counseling

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Goals

The goals of this lesson are to:

1. illustrate how pharmacists can communicate better with their patients; and
2. present specific examples of communication errors and suggest how they can be avoided.

Objectives

At the conclusion of this lesson, the successful participant will be able to:

1. identify specific reasons why pharmacist/patient communication is important;
2. select correct interpretations of commonly used terms;
3. choose from a list, specific duties which studies have shown that pharmacists should perform as part of their professional responsibilities; and
4. identify specific barriers and other influences that interfere with good communication.

One-half of all Americans take their medication incorrectly. They take it at the wrong time, in the wrong dosage, or take it concurrently with other drugs that interact.

Reports have demonstrated that patients expect personal attention and professional services from the pharmacist. Popular magazines and pharmaceutical association notices encourage the public to consult a pharmacist about their drug questions. Many physicians, and even the FDA, are advising Americans to establish a good rapport with a pharmacist.

This article examines pharmacist/patient communication. It illustrates the level of communication that currently exists, and offers suggestions for improvement.

Pharmacists Talk to Their Patients

Pharmacists may have convinced themselves that they do communicate drug information to their patients. Most pharmacists talk to their patrons. They often begin an encounter with, "Hi, how are you?" or "May I help you?" Then, while completing the transaction they may inquire about the patient's family, or comment about the weather, sporting events or the world political turmoil. As they hand over the prescription, perhaps encased in a paper bag, they announce the price and indicate that "Your doctor says you should take one tablet stat, then three times a day. Call me if you have any questions about your script. And thank you for your business."

True indeed! The pharmacist talked to the patient and communicated his appreciation for shopping the pharmacy. But throughout the encounter, how much actual communicating of health-related information actually transpired? Did the patient truly understand what his medication was for? Did he understand what "stat" and "three times a day" meant? And what about OTC products or food or alcoholic beverage interactions? The patient may not think about these questions until he is ready to take his medication.

The 1975 Millis Commission Report indicated that pharmacists of the future will function as

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in the service of pharmacy

This continuing education for Pharmacy article is provided through a grant from

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CORRESPONDENCE COURSE

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transmitters of information. The Commission reported that "... the greatest failing of pharmacy is its inadequacy as an information transmitting system." It urged pharmacists to command principles of communication and use them because future pharmacists will dispense more information than medication. Unfortunately, studies have shown that as little as 5 to 6 percent of pharmacists' time is actually spent in consulting with patients.

Unconvinced that American consumers want more personal consultation and information? Then browse the shelves of any bookstore. Dozens of books have been written for the lay public that deal with various topics in health, including books that give specific information on prescription and OTC drug items. In fact, the *Physician's Desk Reference* (PDR) is one of the most popular books purchased by consumers and consulted in libraries across the country. It has appeared in the "Top 10" list of best sellers numerous times.

The pharmacy literature stresses that good pharmacist/patient communication is paramount to professional practice today. Speakers at professional meetings also encourage good communication.

This information may be misleading to pharmacists who are interested in promoting communication. Communication specialists often assume that pharmacists can spend unlimited cash to hire others to perform many of the duties that will give them time to communicate, or to rearrange the pharmacy layout and purchase necessary furnishings. They also assume that pharmacists have time to attend college classes to learn basic communication skills, or, that they can start the first day to communicate effectively with all their patients. This lesson presumes none of these.

Make the Commitment

Fast or Slow? There are two theories on how fast a communication program can be initiated. The first states that it is best to jump right in and counsel everyone. An advantage is that most mistakes will be made early on and pharmacists should benefit from extensive practice.

The other opinion stresses that pharmacists should begin slowly. Aristotle said "... you learn to play the flute by playing the flute!" In other words, pharmacists should try counseling a limited number of patients on the first day and maintain this schedule until they feel comfortable to expand. Or, they can concentrate at first on patients who receive certain types of medication, such as birth control regimens, antibiotics, or ingrown toenail remedies. Once mastered, the number of patients can be increased each day until all who need counseling receive it.

Move Buffers and Barriers. Pharmacists' work areas have evolved around numerous barriers to good communication. Clerks represent one of the greatest barriers. A clerk assigned to the prescription receiving area may be the only person the patient encounters. The clerk meets and greets the patient, transmits the prescription to the pharmacist, then often returns the medication to the patient who then questions the clerk about the prescription. The clerk may respond and the pharmacist is never involved in the counseling process. Unfortunately, neither patient nor clerk knows what questions or information are pertinent. The pharmacist then is actually dispensing to the clerk.

The prescription countertop is another barrier. This is typically a 4 to 5 feet high, 2 to 3 feet deep structure that very effectively shields the pharmacist from his patients. It is frequently topped with promotional displays or lined along the rear with fast moving prescription items and a backlog of third-party record forms and remnants of yesterday's lunch. The poor patient just doesn't have a chance to communicate in this setting.

Then too, a raised platform behind this counter may elevate the pharmacist. Such elevations permit pharmacists to observe store activities and certainly raises them to positions of authority. But this subconsciously intimidates patients so they do not feel comfortable communicating on a one-to-one basis. So the setting for poor communication is further fostered.

Table I lists other barriers that interfere with open and effective communication. Many are obvious; others may not be. They should be identified and removed. Usually little or no expense is involved. Wholesaler merchandise can often be received in another section of the pharmacy or kept out of sight until it can be put away. Seasonal display units that require floor space can be moved away from the pharmacy area. All other displays, signs, and objects that may distract a patient during communication should also be moved.

Merchandise and displays can be removed from the top of the prescription counter. And better yet, pharmacists can come out from behind the counter and stand at eye level with their patients to communicate with them.

Clerks can be instructed to receive and

Table 1

Common Barriers to Pharmacist-Patient Communication

- High counters and pharmacy counter clerks
- Language barrier and ethnic differences
- PPIs, books, auxiliary labels and printed directions sheets
- Poor pharmacy layout; noisy or active waiting area
- Merchandise on floor or countertops that distract patients
- Other patients waiting who may overhear
- Age differences (i.e., young pharmacist in a community of older persons)

transmit a patient's prescriptions, but the medications should be dispensed directly by the pharmacist. This same clerk can engage in conversation with other patients who are waiting, to help temper their anxiety from having to wait for the pharmacist. More importantly, this makes the person with whom the pharmacist is currently serving feel more relaxed. High anxiety is correlated with low recall. Clerks should be instructed to answer all questions that do not relate to drugs or disease. The clerk's answer may be inadequate, incomplete, or even incorrect! Such questions should only be answered by the pharmacist.

Make the Time. Moving barriers and clearing the aisles are easy. Finding the extra time to spend in counseling patients is another matter. An average patient counseling session should not require more than 1 to 2 minutes. But this time, multiplied by the number of patients needing it, adds up.

First, time is not found. It is made! Appoint another person to handle nonprofessional chores such as routine mail opening, stocking and dusting, checking in orders, building displays and answering the telephone. Even responsibilities such as completing third-party forms and price changing can be delegated to a trusted clerk. Professional journals and reading material can be taken home to study.

Ask a pharmacist colleague to spend a few hours observing you and recommend specific areas where a change in operation will produce significant time savings. Maybe you can return the favor to them or to another colleague.

Set definite goals for each day and prioritize them. List them on a 3×5 card, and keep it in view throughout the day, and proceed according to this schedule. Time efficiency experts claim that many minutes will be added to each working day by having activities planned in advance. These added minutes can then be devoted to patient counseling.

Many pharmacy journal advertisements and other printed pieces contain diagrams, figures and pictures that make excellent reference material for patient counseling use. Start a filing system for such information and keep it current. Use this to demonstrate specific points to a patient. A description of how gastric acid secretion is halted by an H_2 blocker, for example, or how to correctly brush and floss the teeth will be more easily understood, and longer retained, when such illustrations are used.

The total time needed with each patient may be decreased by not having to verbalize some of the concepts. Only material that is easily understood and figures that are clear should be used. Extraneous words and artwork can distract the patient's attention, confuse him, and require the pharmacist to spend more time than necessary to explain what it all means.

Clear off the prescription counter work area. If there is not a separate office area or desk, set aside an unused portion of the prescription counter to serve this function. Separate it from the area devoted to prescription activities. Do not waste time repeatedly searching for items that are usually covered beneath piles of papers, advertising copy, books, order forms and other collectables. Items that aren't used each day should be moved elsewhere, out of the way. More precious minutes are thus gained.

Frequently dispensed medications should be brought closer to the work area. Log all movements into each bay or shelf area for a couple days. Decide which items need to be moved closer to the counter, then move them.

Schedule Patient Visits. Many days have periods that are busier than others. During these rushed times, counseling patients may be especially difficult. The following suggestion isn't appropriate for every patient, but it will work for some.

First, keep an accurate record of prescription filling activity during each 30 minute segment for the next 2 to 3 weeks. Record the number of

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CORRESPONDENCE COURSE

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prescriptions filled and indicate whether they were new or refills. A definite pattern of activity should emerge. Then, suggest to selected individuals who normally bring in refills during these busy periods that they may wish to come at another time. Or, ask them to call in their refill prescription number(s) in advance. When they do come in, you can spend more time discussing their health questions and drugs.

In one survey of pharmacy patients, 70 percent admitted that if the pharmacist looked extremely busy, they would not bother him with questions. And the majority indicated that unless more pressing circumstances prevailed, they would gladly come to the pharmacy when the pharmacist was not as busy.

Say it Correctly

Health professionals communicate through a common language that is understood by other health practitioners. But it may mean little or nothing to a patient. Imagine a patient casually being told to take a "stat" dose of medication, or to take it "pc!" Pharmacists casually tell their patients that "The 'sig' on your script is..." and so on. Even medical terminology such as pediculosis, tinnitus, hyperkalemia or hypertension may confuse the patient.

But don't talk down to patients either. Use terms they can understand. Start by putting them at ease and tell them you are interested in making sure they fully understand the directions.

Learn to communicate the ideas you want stressed and to elicit the specific information you need from a patient. To avoid misunderstanding and minimize incorrect or incomplete information being given, refer to the questioning techniques in Table 2.

Label Instructions

Instructions on the label are also open for misinterpretation. Prescription labels that otherwise seem clear to both pharmacist and patient at the time of dispensing may be confusing at the time of administration. A study illustrated this point.

Outpatients in a clinic pharmacy were asked to interpret the labels on each of ten prescriptions. The labels contained commonly used phrases. For a prescription for propoxyphene HCl, for example, patients were instructed to "Take one capsule every four hours as needed for pain". They were encouraged to question the pharmacist to help clarify the directions. Questions relating to effectiveness, side effects, refills, drug interactions and other warnings and precautions were asked. But no one asked what "as needed" meant.

The patients were then asked to assume they took a capsule at 8 a.m. If pain were still present at 10 a.m., could another dose be taken? Approximately 20 percent responded affirmatively. In fact, when there were asked to state how many capsules could be taken each day, about half responded incorrectly with answers ranging from two to eight.

In another investigation, patients were asked to interpret the meaning of a label affixed to their antihypertensive medication which stated, "This prescription cannot be refilled." Seven percent believed it meant that the medication did not need to be taken any longer.

Similar confusion in label instructions still exists for some OTC products. For example, one

Table 2

OPEN ENDED. Good way to open conversation. Example: "What other medication are you taking?" Questions cannot be answered yes or no.

CLOSE ENDED. Answered yes or no. Best to avoid since patient is forced into one of two answers.

DIRECT. Use when more specific information is needed. Example: "You mentioned that the directions were not clear. Which specific part is not clear?"

SUGGESTIVE. Questions suggest that something should or should not happen. Example: "This drug causes sedation. Did you feel tired?" Should be avoided unless they are the only means to get the patient started talking.

REFLECTIVE. Questions begin by commenting on the last few words of patient's statement. If patient remarks that "These tablets made me feel nauseous," then a reflective question could begin, "You feel nauseous...?" Question then would bring out more detailed information. People may feel positive about this type of questioning since it shows the pharmacist is really listening to them.

young girl believed that the contraceptive jelly she purchased was to be spread on her breakfast toast. Months later when she learned otherwise, she also discovered why she had become a mother.

Pharmacists should not assume that patients understand even the most simple terminology. In fact, the major reason people do not take their medication correctly is that they do not understand the directions. The pharmacist should explain the directions for prescription items and OTC medications, and use language that the patient understands. They should then ask that this information be repeated by the patient in his own words.

Nonverbal Communication

The unspoken word is often more suggestive than the spoken. People judge others by the visual impressions they leave. It was shown in one study that only 5 percent of an overall message is conveyed by the spoken word, 55 percent is transmitted by the tone and facial expressions, and 40 percent by body language.

Pharmacists who display a perpetually bewildered look, or always refer to a book or microfiche before answering a question, or constantly clear their throat before talking or keep their head bowed with eyes directed to the floor while talking, may give the impression that they do not know what they're doing. Even small gestures such as furrowing the brow or scratching the head while studying the prescription may send negative vibrations to the patient.

Overview

Communication skills are developed through practice. Not all patients need counseling, but many do. Pharmacists can practice good communication on just a few patients at first and then expand.

Pharmacists should identify unnecessary barriers around the pharmacy and remove them. They should also initiate drug information rather than wait to be asked. Pharmacists can let consumers know that they are ready to serve them by displaying such notices throughout the pharmacy. By using their imagination to discover more ways to improve communication skills, everyone will benefit.

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CORRESPONDENCE COURSE QUIZ
Art of Patient Counseling

1. All of the following are true about patient counseling EXCEPT:
   a. every patient receiving a prescription needs counseling.
   b. the average patient counseling session should not require more than 1 to 2 minutes.
   c. talking to a patient from a raised platform may produce poorer patient compliance.
   d. high patient anxiety is related to poor learning and recall.

2. According to information in this article, which of the following is a major reason people do not take their medication correctly?
   a. Consumer-oriented books explain directions differently than prescription labels do.
   b. People do not understand the directions.
   c. People believe the doctor misdiagnosed them.
   d. People believe the pharmacist overcharged them.

3. Which of the following is a true statement?
   a. Approximately 20 percent of all prescription dollars spent in the U.S. are wasted through non-compliance.
   b. Generally, visuals used in counseling on directions distract the patient and confuse more than help.
   c. Reflective questions are usually resented by patients.
   d. Suggestive questions should be avoided unless no other questioning works.

4. The 1975 Millis Report stated that pharmacists of the future will be:
   a. largely replaced by computers.
   b. more concerned with dispensing accuracy.
   c. principally females.
   d. transmitters of information.

5. All of the following are true statements about pharmacist/patient communication EXCEPT:
   a. most patients want it.
   b. printed directions sheets may confuse the patient.
   c. the end result is better compliance.
   d. FDA advised consumers to establish a good rapport with physicians rather than pharmacists.

6. According to information presented in this article, what percentage of consumers indicated that if the pharmacist looked extremely busy, they would not bother him with questions?
   a. 20
   b. 50
   c. 70
   d. 90

7. Which of the following is the barrier to pharmacist-patient communication of greatest concern according to information presented in this article?
   a. Clerks
   b. Physicians
   c. Registers
   d. Rx counter

8. In a pharmacist-patient encounter, the strongest impression (message) is reportedly conveyed by the:
   a. pharmacist's body language.
   b. pharmacist's tone and facial expression.
   c. physical layout of the pharmacy.
   d. wording of the directions.

9. Which of the following questioning techniques is represented by "Are you following your doctor's directions?"
   a. Close ended
   b. Open ended
   c. Direct
   d. Suggestive

10. The prescription label instructions "Take one capsule every four hours as needed for pain" contains a major point for patient confusion. What is it?
    a. Can two capsules be taken for the first dose?
    b. Does "every four hours" mean around the clock?
    c. What does "as needed" mean?
    d. Is the type of pain important?

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APRIL 1989 VOLUME 69 NUMBER 4

Scene from the 23rd Annual Seminar on Socio-Economic Aspects of Pharmacy Practice sponsored by NCPhA and the UNC School of Pharmacy; *(left)* seminar moderator, Al Lockamy Jr., President, NCPhA and *(right)* Betty Dennis, Director of Continuing Education, UNC School of Pharmacy. **See also page 16.**

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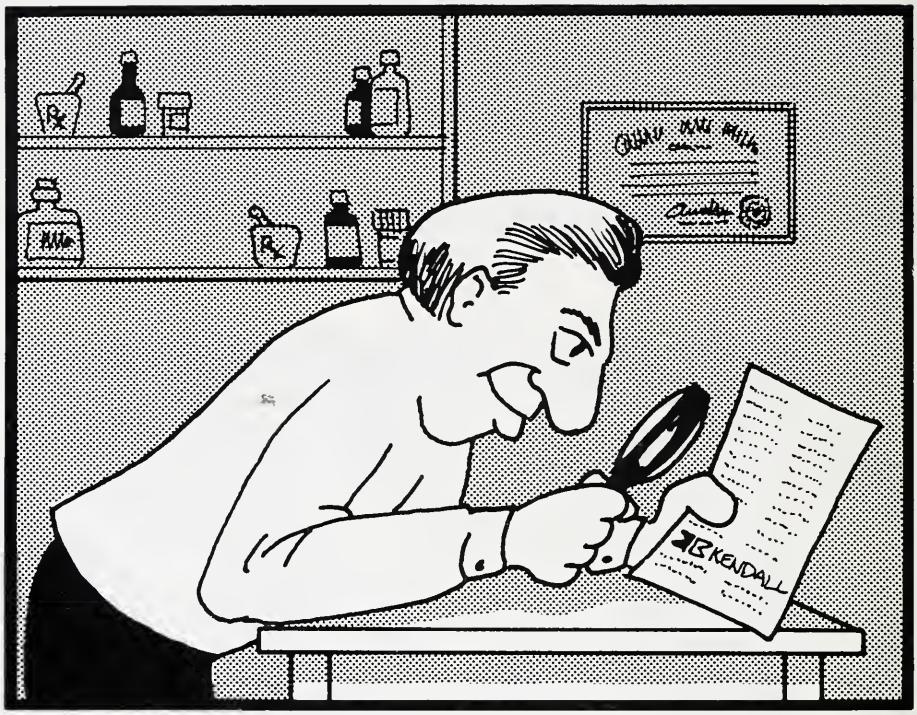

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*Wiggins, Steven N. "The Cost of Developing a New Drug." Pharmaceutical Manufacturers Association, Washington, D.C., June 1987.

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PRESIDENT'S REMARKS

I hope that many of you had the opportunity to see the segment on mail order pharmacies which was shown on *CBS This Morning*, February 8 and 9, 1989. Health Correspondent, Dr. Bob Arnot, presented the results of a several week long investigation conducted by CBS on mail order pharmacies. The focus of his investigation centered on National Rx Services in Las Vegas, Nevada, a subsidiary of the mail order pharmacy, Medco.

In 1988, the company was charged with manslaughter for the death of a woman in Moscow, Idaho, due to an alleged mix up in her prescription medication. The victim of the medication error, Iris Hemmelman, allegedly received Coumadin 5 mg instead of Prednisone 5 mg from the mail order pharmacy. She died in January 1988 of a massive acute cerebral hemorrhage as a result of Coumadin poisoning. The County Prosecutor who filed the case said the mistake was made because of the company's high speed, error prone, assembly line operation.

Mail order pharmacies have become a billion dollar a year business in the last 4 years. Their popularity has grown because of their convenience and the cheaper prescription drugs they sell. Many, however, question the safety of mail order pharmacies and whether or not a true cost savings can be obtained, as some studies have indicated the contrary.

Drs. Hartzema and Phillips at the Department of Pharmacy Administration, UNC School of Pharmacy, published an excellent article describing the issues surrounding mail order pharmacies in the December 1987 issue of *The Carolina Journal of Pharmacy*. (If you don't recall the details of this article, please take the time to review it.) For example, the authors noted the following regarding the cost of mail order services:

> In a study of claims covering a one-year period, Pharmaceutical Card System (PCS) Inc. found that the costs of mail order prescriptions were 5% higher than conventional pharmacy services, primarily because of the excess volumes mail order houses dispense, e.g., 90 day supply minimums and automatic refill mailings. Moreover, they found the losses increased the longer the program was in place.
>
> Officials from Ford Motor Company reported that the costs of its mail order program was approximately 1.5-1.7% higher than a comparable community pharmacy program.

Others have pointed out that the cost savings some individuals do obtain from mail order pharmacies is due to the extensive use of generic pharmaceuticals and the fact that many mail order firms are loss leading their products to gain market share (which, of course, won't continue when these businesses mature).

A few individuals are doing something about stopping mail order pharmacies as indicated in this month's " Dickinson's Pharmacy." Senator Jim Sasser (D-Tenn) is another individual who is trying to put a stop to mail order pharmacies. Senator Sasser has held congressional hearings to investigate numerous complaints he has received from consumers all over the country. Winifred Owens of Virginia Beach testified at the hearings that she ordered the drug Corgard for her hypertension, but received Coumadin instead. Only because Ms. Owens was astute enough to call her neighborhood pharmacist, rather than take the tablets she obtained by mail, did she avoid serious harm.

Continued on page 6

Unfortunately, many patients who choose to use a mail order pharmacy may not be as perceptive or discerning. Particularly vulnerable are the elderly as they are becoming a growing user of mail order drug vendors. Seven and a half million prescriptions are dispensed by the American Association of Retired Persons, AARP, Mail Order Pharmacy Service each year. Officials of AARP have publicly announced they will increase their current market penetration from 3% to 10%.

Companies, like Kodak and Amoco, that have contracted with mail order firms to provide drug benefits to their employees, often times *require* their employees to use mail order services. Other companies allow the choice between community pharmacies and mail order pharmacy services, but provide incentives such as reducing copayments for the use of mail order pharmacies.

Both APhA and NARD are also actively pursuing the curtailment of mail order pharmacy services. Both have formulated recommendations to guide their efforts. APhA's recommendations center around drug therapy monitoring activities, in particular, the flow of information between physicians, patients and pharmacists; NARD's recommendations can be summarized as public health concerns, and include the importance of the pharmacist's role in patient health status assessment, patient education, emergency provisions and compliance reinforcement.

What can you do to prevent mail order pharmacies from spreading further?

1) Write to your state and national legislators? A booklet entitled, "Make Your Voice Heard," contains tips on how to write letters to your legislators. Free copies of this booklet will be mailed to all NCPhA members in the next month.

2) Report any problems with mail order pharmacies you hear about from disgruntled customers to our Executive Director at NCPhA, Al Mebane. He will, in turn, make sure our leaders on the state and national level are informed of these specific instances.

3) Educate your customers about the misconceptions of mail order pharmacies. You may even want to distribute to your customers the anti-mail order brochure published by NARD. These brochures can be obtained from NCPhA by calling 1-800-852-7343 (in state) or 919-967-2237.

4) Take a personal interest in your customers. Develop a personal relationship with them. Let them know your service is an important one. Get out from behind the counter and talk to your patients about their medications and reinforce medication compliance.

It is up to you and me to do something about mail order pharmacies. All too often people avoid their responsibilities or procrastinate their duties. Don't think mail order pharmacies are someone else's problem. If you don't educate your legislators and your customers about the deceptions of mail order pharmacies, who will? Perhaps, more importantly, who will help your customers realize the value of a pharmacist's services unless you do? What sort of impression do you think we pharmacists made on Iris Hemmelman for her to subscribe to such inferior pharmacy services? Just think, had Iris Hemmelman realized the importance of pharmacists' services, she could be alive today.

Al Lockamy, Jr.
President, NCPhA

Note: If you missed the CBS segment on mail order pharmacies and would like to see it, you may borrow NCPhA's videotaped copy.

References:

Hartzema, A.G. and Phillips, J.H. "Mail order pharmacy: a real or perceived threat to the economic future of retail pharmacy." *The Carolina Journal of Pharmacy*. December 1987. vol. 67, no. 12: pp. 7-14.

Excerpts from "Mail order drug programs: a serious threat to the public health" presented by Charles M. West, Executive President, NARD, at the Ohio Pharmaceutical Seminar on April 13, 1988.

"NC Pharmacy leaders convene at the fifth annual pharmacy leaders forum." *The Carolina Journal of Pharmacy*. March 1989, vol. 69, no. 3: pp. 6-11.

VIVIA CREECH NAMED AN N.C. "WOMAN OF DISTINCTION"

Vivia Creech

Vivia Rives Creech of Smithfield was honored as one of five "North Carolina Women of Distinction" by the N.C. Council of Women's Organizations last weekend in Raleigh.

The Council includes 49 statewide women's groups. Mrs. Creech was nominated for the award by the Woman's Auxiliary of the North Carolina Pharmaceutical Association. Her husband, James L. Creech, is the owner of Creech Pharmacy in Smithfield. Their daughter, Mary Gulledge, is an English teacher at Enloe High School in Raleigh.

Mrs. Creech has lived in Smithfield for more than 50 years and has been involved in all areas of church and civic affairs.

She is past president of the Women's Auxiliary of the N.C. Pharmaceutical Association and has served on many committees, including the one for the Association's 1980 Centennial celebration in Raleigh.

Mrs. Creech was instrumental in gaining space in the state's Museum of History for a drug store, circa 1925. She is a member of the Museum of History Associates.

She was chairman of Smithfield's 1977 Bicentennial Celebration, which included a wide variety of events spanning the month of April.

She is a member of the Johnston County Constitution Bicentennial Commission, which is planning a musical drama based on Johnston County history for presentation in celebration of the 200th anniversary of North Carolina's ratification of the U.S. Constitution and Bill of Rights. As a member of the Commission, she planned a 1987 Johnston County forum featuring Joseph Branch, former chief justice of the N.C. Supreme Court, and Justice Louis Meyer as speakers.

She is co-chairman for restoration of the one-room Barnes Crossroads Schoolhouse which now rests on the campus of Johnston Community College. And she is working toward making the old school a teaching tool for fifth-grade teachers in Johnston County.

A former teacher, Mrs. Creech is a member of the Alpha Beta Chapter of Delta Kappa Gamma Society International and the Johnston County Retired Teachers Association.

She is a member of Centenary United Methodist Church, and is a past president and life member of the Women's Society of Christian Service. She has served as Sunday School teacher and member of the administrative board, altar guild, committee on history, and chairman of the church's celebration of 200 years of Methodism in America.

Mrs. Creech's main hobby is flower arranging. She is a past president of the Smithfield Garden Club, and she has presented many programs and workshops for local and out-of-town groups. She has also given her time and talent to provide floral arrangements for special events both near and far.

During the past four decades, Mrs. Creech has directed approximately 125 weddings, all free of charge for friends and neighbors.

In making the nomination for "Woman of Distinction," Rose Boyd, president of the Woman's Auxiliary of the N.C. Pharmaceutical Association, wrote: "It has been said that one fears for Smithfield when Vivia is out of town. This statement confirms that Vivia Rives Creech is surely a 'Woman of Distinction.' "

The "Women of Distinction" awards have been presented since 1987. Mrs. Creech is the first Johnstonian to receive the honor.

In addition to Mrs. Creech, 1989 honorees are: Dr. A. Helen Martikainen, a former chief of health education for the World Health Organization in Geneva, Switzerland; Betty Ann Knudsen, a former Wake County commissioner; Katherine L. Harrelson, Northwestern regional coordinator for the N.C. Council on the Status of Women; and Mary Cornwell, former Extension home agent and founder of "The Village of Yesteryear" at the N.C. State Fair.

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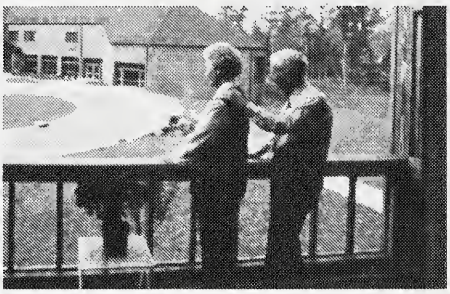

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LILLY DIGEST AVERAGES OF SELECTED OPERATING STATISTICS
1988 LILLY DIGEST NORTH CAROLINA SUMMARY

The following chart summarizing data from the 1988 "Lilly Digest" has been provided by Eli Lilly and Company. In addition to the regional comparison between 1987 and 1988 data, the chart reflects data from North Carolina pharmacies which participated in the voluntary survey process.

AVERAGES PER PHARMACY	1987 NORTH CAROLINA (50 Pharmacies)	1987 SOUTH ATLANTIC REGION (216 Pharmacies)	1987 AVERAGE UNITED STATES (1,806 Pharmacies)
SALES			
Prescription	$476,299— 68.4%	$451,899— 73.7%	$450,815— 66.5%
Other	219,819— 31.6%	161,113— 26.3%	227,333— 33.5%
Total Sales	$696,118—100.0%	$613,012—100.0%	$678,148—100.0%
COST OF GOODS SOLD	484,308— 69.6%	417,741— 68.1%	460,660— 67.9%
GROSS MARGIN	$211,810— 30.4%	$195,271— 31.9%	$217,488— 32.1%
EXPENSES			
Proprietor's or Manager's salary	$ 41,955— 6.0%	$ 41,209— 6.7%	$ 42,650— 6.3%
Employees' Wages	64,660— 9.3%	54,670— 8.9%	63,588— 9.4%
Rent	14,875— 2.1%	13,034— 2.1%	15,931— 2.4%
Miscellaneous Operating Expenses	67,564— 9.8%	62,267— 10.2%	72,607— 10.7%
Total Expenses	$189,054— 27.2%	$171,180— 27.9%	$194,776— 28.8%
NET PROFIT (before taxes)	$ 22,756— 3.3%	$ 24,091— 4.0%	$ 22,712— 3.3%
Add proprietor's withdrawal	41,955— 6.0%	41,209— 6.7%	42,650— 6.3%
TOTAL INCOME OF SELF-EMPLOYED PROPRIETOR (before taxes on income and profit)	$ 64,711— 9.3%	$ 65,300— 10.7%	$ 65,362— 9.6%
VALUE OF INVENTORY AT COST AND AS A PERCENT OF SALES			
Prescription	$ 53,573— 11.2%	$ 48,133— 10.7%	$ 47,096— 10.4%
Other	42,627— 19.4%	33,659— 20.9%	48,790— 21.5%
Total Inventory	$ 96,200— 13.8%	$ 81,792— 13.3%	$ 95,886— 14.1%
ANNUAL RATE OF TURNOVER OF INVENTORY	5.2 times	5.2 times	4.9 times
FLOOR AREA*	3,753 sq. ft.	2,656 sq. ft.	2,824 sq. ft.
SALES PER SQUARE FOOT*	$192.28	$233.13	$233.02

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LILLY DIGEST OPERATING STATISTICS

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AVERAGES PER PHARMACY	1987 NORTH CAROLINA (50 Pharmacies)	1987 SOUTH ATLANTIC REGION (216 Pharmacies)	1987 AVERAGE UNITED STATES (1,806 Pharmacies)
RENT PER SQUARE FOOT*	$3.97	$4.90	$5.64
NUMBER OF PRESCRIPTIONS DISPENSED			
New	17,314— 53.2%	17,695— 60.4%	18,322— 62.5%
Renewed	15,214— 46.8%	11,589— 39.6%	11,011— 37.5%
Total Prescriptions	32,528—100.0%	29,284—100.0%	29,333—100.0%
PRESCRIPTION CHARGE	$14.64	$15.43	$15.37
NUMBER OF HOURS PER WEEK			
Pharmacy was open	61 hours	58 hours	60 hours
Worked by proprietor	56 hours	56 hours	54 hours
Worked by employed pharmacist(s)	25 hours	27 hours	31 hours

*Based on averages of pharmacies that reported all data.
**Source: 1988 *Lilly Digest*

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The Joining Up Process

This is the fifth in a series of articles for professionals who manage and managers who lead professionals and those who are both. Pharmacists operate with one license, but fill many different professional roles in hospitals, chain stores, individual stores, drug companies and universities. Along the way they need a broad variety of management skills. These articles take a broad perspective on management concepts we hope you will be comfortable applying.

Curtis P. McLaughlin

In the last article we identified the joining-up process as one of the keys to effective management of professionals. That process involves recruitment, selection, placement, and training. What is most important is to have the new employee come out of that process with appropriate and realistic expectations about the job. That process can be viewed as one of developing a very specific psychological contract upon which the relationship between the employer and the employee is based.

Do I call in a lawyer and have her draw up such a contract? Heavens, no. We are not talking about a legal instrument. That is why it is called a *psychological contract.* Even though it is seldom reduced to paper, I am convinced that it is a key ingredient to ending up with motivated professionals.

The psychological contract is a verbal process in which the manager and the prospective professional employee spell out in detail the expectations that each has of the job. Remember that professionals are very touchy about their professional autonomy and like to feel that they are acting on their own without coercion. So what you want them to do is to have an internal compass that leads them to do what you would want them to do anyway.

When I used to be a research laboratory administrator, I heard of a young man who, after getting his Ph.D. from CalTech, was offered a job doing basic research for an aircraft manufacturer. He had been told that he could do research on anything he wanted to. When asked what interested him most, he said that he was entranced by the stresses and structures of wings. The airplane company had no problem. He could do what he wanted to because it was what the company wanted anyway. That is the best-of-all-possible-worlds in managing professionals.

Isn't that what most employment interviews are about anyway? Usually, but some key steps are often missed in that process, if one stays with the usual items of salary, working hours, and fringes. But in jobs where the professional employee is responsible for safety, for the quality of the interaction with the customer, for advising the customer, for selling additional services, there are many other issues to be negotiated.

Not the least of these is the need to have an understanding of where and how to renegotiate the contract as the needs of the business dictate. Suppose that the young aerodynamicist mentioned above shifted his interest to the migrational habits of butterflies. Then he and the aircraft manufacturer would have to renegotiate their contract that he could work on whatever interested him. Each psychological contract should contain a provision that the contract is to be renegotiated at regular intervals to take into account new realities.

There are many items that could be included in the contract where professionals are involved. It

Continued on page 12

CURTIS P. MCLAUGHLIN is a Professor of Business Administration in the School of Business and Professor of Health Policy and Administration in the School of Public Health at the University of North Carolina at Chapel Hill. McLaughlin received his masters and doctorate degrees in Business Administration from Harvard Business School. He has written numerous management articles for a variety of publications, including Harvard Business Review, and has consulted for domestic and international corporations. Some of his professional interests include the production of professional services in research, engineering, medicine, public health and education; management of not-for-profit organizations; and productivity improvement.

THE JOINING UP PROCESS

Continued from page 11

can include the degree of professional autonomy involved and in what areas. It can include what the professional has to put up with in terms of abusive behavior by clients and customers or even government officials, before it is legitimate to turn the matter over to a supervisor. It can include discussion of the career ladder that is to be followed and the expected timetable. Increasingly there is room to discuss the attention that is to be given to matters of rearing children and to other needs of family life.

Wilson and McLaughlin suggested that the contract for professionals in an academic medical center might look like the following:[1]

Employee Gets

Salary, relative to cost of living
Personal development opportunities
Recognition for good work
Security, so long as funds are available
Supportive environment
Fair treatment
Meaningful and purposeful work
Reasonable conflict and tension levels, mediated by clear standards for priority setting, personnel evaluation and job security
Personal courtesy and respect
Opportunities to develop and be ready for promotion, although it may not be rapid
Participation in priority setting
Performance standards to meet that represent realistic tradeoffs between funds, personnel, time schedules, and levels of service.
Psychological-contract change processes that reflect changing resource conditions.

Organization Gets

An honest day's work, at least
Loyalty to the organization
Conformity to organizational norms
Job effectiveness and efficiency in meeting overall objectives
Flexibility and a willingness to wear multiple hats under tight staffing
Acceptance of reasonable tradeoffs between professional norms and organizational needs
Employee learns the organization's strategy, goals and environment
Access to professional and community recognition for the organization
Psychological-contract change processes that reflect changing resource conditions.

You can certainly add other items that fit your practice setting. An example is how to handle situations where there are potential drug interactions. How much initiative is the pharmacist to take? Who is to handle the potential complaint from the physician who disagrees or is irritated by being caught in an error? If the physician tries to ignore or override the pharmacist, what is to be management's position? Some of these professional areas will be addressed through corporate policies and procedures, but others are legitimate subjects for the psychological contract.

The notion of the psychological contract goes beyond the above list. It also exists in the budgetary process. In many government agencies this is overlooked. The professionals in the agency are asked to submit a work plan and a budget which shows a relationship between the amount of services to be rendered and the budget. Then the request disappears into the budget process for several months only to emerge at the last moment when the headquarters calls, giving the agency its final (much lower) budget figure and requesting a revised budget to meet that figure. At that point no mention is made of any revision of the corresponding service objectives. Consequently, the agency has a high set of objectives and an unrelated, lower budget. Since management has also chosen to ignore the relationship between output and input, management has also chosen to abrogate any implied psychological contract concerning the relationship between the output expected from the employees in return for the resources provided. The net result is an attitude that no one cares about productivity around here.

Annual personnel reviews present a natural opportunity for renegotiating the psychological contract. But it depends on an understanding by both sides of what the original contract was and how and why it should be changed. My experience is that, where there is such an understanding, the employees usually enter the negotiation process with as much foresight about what should be changed as management does. For example, in the university, when there has been a thorough discussion of teaching assignments and rotations out into the future, when there is a need to change to respond to an emergency, the individuals have already identified the alternatives and are resigned to the consequences, even before the supervisor brings the subject up. That is the way it should be with professionals. They should be given enough contextual information by management to be able to see what is needed

Continued on page 25

PHARMACIES WITH PHYSICIAN OWNERSHIP

In addition to the almost 600 physicians registered with the Board of Pharmacy to dispense medications, the following is a list of pharmacies in NC involved with some physician ownership.

Village Pharmacy of Advance, Inc., Rt. 1, Box 9, Advance, NC 27006

Asheville Home Therapeutics, Inc., 445 Biltmore Ctr., Suite G 105, Asheville, NC 28801

Med Center I, Carteret Family Practice, Atlantic Beach, NC 28512

Catawba Pharmacy, 403 Catawba Street, Belmont, NC 28012

Northside Pharmacy, Inc., 80-A Hickory Grove Rd., PO Bx 1341, Belmont, NC 28012

North Carolina Home Therapeutics, Inc., 1112 Harding Place, Suite 100, Charlotte, NC 28204

Davie Discount Drugs, Cooleemee S/C, Cooleemee, NC 27014

Lincoln Community Hlth. Ctr., 1301 Fayetteville St., PO Bx 52119, Durham, NC 27707

Cumberland Home Therapeutics, Inc., 1643 Owen Dr., Suite A, Fayetteville, NC 28304

Primary Care Plus, 1905 Skibo Rd., Fayetteville, NC 28304

Garland Clinic Pharmacy, PO Bx 116, Garland, NC 28441

Eastern Car. Surg. Ctr. Pharm. Ltd. Ptnrshp, 102 Bethesda Drive, Greenville, NC 27834

Harrells Pharmacy, Hwy. 411, PO Bx 89, Harrells, NC 28444

Fairbrook Clinic Pharmacy, Rt. 3, Box 155, Hickory, NC 28602

Hudson Drug Company, Inc., PO Bx 33, Hudson, NC 28638

Piedmont Pharmacy of Lawndale, Inc., Lawndale, NC 28090

Community Drug Store, Inc., 206 W. Center St., PO Bx 683, Lexington, NC 27293

Center Street Pharmacy, Inc., 316 East Center Street, Lexington, NC 27292

New Bern Outpatient Surgery Center, Inc., 801 College Dr., PO Bx 2446, New Bern, NC 28560

Family Practice Pharmacy, 444 Howard Blvd., Newport, NC 28570

Family Pharmacy of Old Fort, Cor. RR & Thompson, PO Bx 1299, Old Fort, NC 28762

Barbee Pharmacy, Inc., 118 Campus Ave., Medical Complex, Raeford, NC 28376

Jim's Discount Drugs, Inc., 220 N. Main St., Randleman, NC 27317

Tar Heel Drug Co. of Robbins, Inc., N. Middleton St., PO Bx 548, Robbins, NC 27325

College Pharmacy, PO Bx 285, Rutherford College, NC 28671

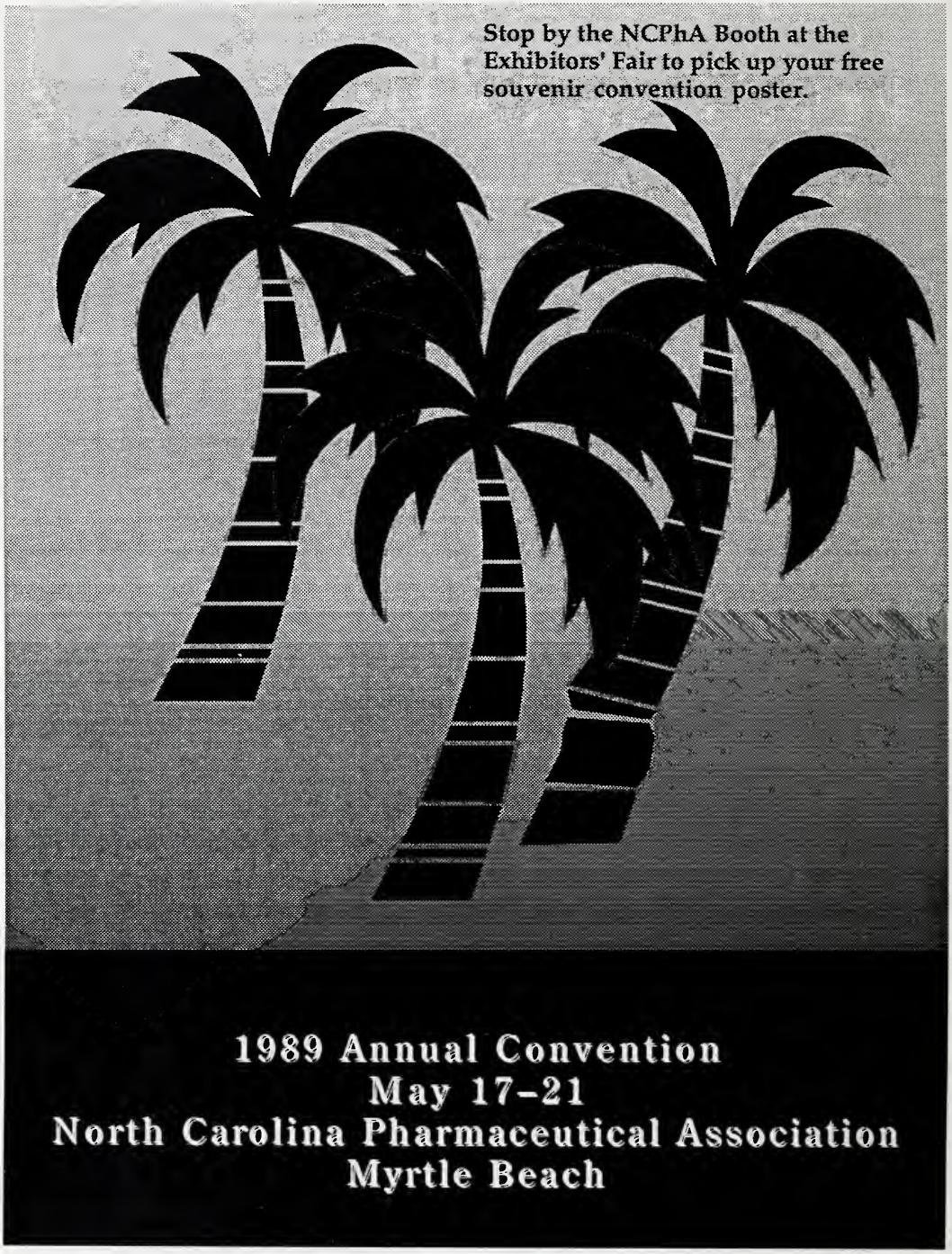
Hospital Pharmacy, 601 E. 12th. Street, Washington, NC 27889

Tayloe Drug Company, 239 W. Main Street, Washington, NC 27889

Weaverville Drug Company, Main Street, Weaverville, NC 28787

Triad Home Therapeutics, Inc., 1410-A Millgate Dr., Winston-Salem, NC 27103

W-S Health Care Plan Pharmacy, 250 Charlois Blvd., Winston-Salem, NC 27103


Stop by the NCPhA Booth at the Exhibitors' Fair to pick up your free souvenir convention poster.
1989 Annual Convention
May 17-21
North Carolina Pharmaceutical Association
Myrtle Beach

AROUND THE STATE

In response to the recent Readers' Survey conducted by The Carolina Journal of Pharmacy, this column, featuring news around the state, has been resurrected from the past. The NCPhA staff welcomes your comments and any contributions you wish to make to this column. Photos are also welcome. Send us your news!

Appointments

The following NC pharmacists will serve on the Committees listed below:

NARD's 1989 Standing Committees:

Albert F. "Al" Lockamy Jr., Raleigh, Consumer Affairs & Public Relations

Ralph Ashworth, Cary, Home Health Care Pharmacy Services

Rex A. Paramore, Nashville, Long-Term Care Pharmacy Services

F.M. "Mike" James, Raleigh, Management

Mitchell W. Watts, Concord, Multiple Locations

Al Mebane, Chapel Hill, National Legislation & Government Affairs

J.R. Whitehead, RTP, Professional Relations

Julian C. Upchurch, Durham, Third-Party Payment Program

1989-90 APhA Committees

Margaret C. Yarborough, Cary, Specialty Council on Nuclear Pharmacy, Cognitive Services Working Group

Richard J. Hammel, Raleigh, Policy Committee on Scientific Affairs

Carl Taylor, Ahoskie, *American Pharmacy* Editorial Advisory Board

J. Heyward Hull, Chapel Hill, Awards Committee, Academy of Pharmaceutical Research and Science

Albert F. "Al" Lockamy Jr., Raleigh, Executive Committee, Academy of Pharmacy Practice and Management

Stephen M. Caiola, Chapel Hill, Community Pharmacy Residency Program

Margaret C. Yarborough, Cary, **Priscilla C. Brown**, West Jefferson, and **William T. "Bill" Sawyer**, Chapel Hill, have been appointed to the Board of Pharmaceutical Specialties, BPS. Since its creation in 1976, BPS has recognized 3 specialties in pharmacy: nuclear pharmacy, nutritional support pharmacy, and pharmacotherapy.

Kim Deloatch, clinical instructor in the division of pharmaceutics at the UNC-CH School of Pharmacy has been elected 1988-89 chair-elect of the Research Triangle Society for Instructional Development, a local affiliate of the National Society for Instructional Development. The Society consists of members primarily from higher education, industrial training, and human resources who are interested in improving employee performance.

Promotions

J.R. "Joe" Whitehead of Raleigh has been appointed vice president of corporate affairs at Burroughs Wellcome Co. effective March 1. He succeeds Thomas E. Kennedy who is retiring after 17 years. Whitehead joined B-W in 1957 as a medical sales representative and has served in a number of positions with the company. He has been director of government and professional affairs since 1983. He received his B.S. degree in pharmacy from Butler University in Indianapolis in 1954 and M.B.A. in 1960 from Xavier University in Cincinnati. Whitehead is an active member of the NCPhA and numerous other pharmacy organizations. He is also an adjunct assistant professor at the UNC-CH School of Pharmacy and serves on the Dean's Board of Advisors for the School of Pharmacy at the Medical College of Virginia and the Presidential Board of Advisors at Campbell University.

In The News

H.M. Poythress has used soda fountains, bars, bottles, signs and memorabilia from drug stores around the country to recreate an old-fashioned drug store in the dining room of his Pizza Inn on U.S. 70 in Goldsboro. Poythress wanted to recapture the days when the drug store was the place where all the kids gathered after school for a milk shake, soft drink, and conversation. The **Wayne County Pharmaceutical Society** presented Poythress a framed certificate expressing area pharmacists' appreciation for his tribute to the profession. Mr. Poythress owns a total of 15 Pizza Inns in NC. *Continued on page 16*

SCENES FROM THE FEBRUARY 23, 1989 23RD ANNUAL SEMINAR ON SOCIO-ECONOMIC ASPECTS OF PHARMACY PRACTICE

Greensboro, North Carolina
sponsored by NCPhA and the UNC School of Pharmacy

Guest speaker, W.H. "Skip" Weldon, Jr., whose talk covered "Financial Management Issues in Pharmacy Practice." *Staff photo.*

Earle W. "Buddy" Lingle, Ph.D., Assistant Professor, Pharmacy Administration, College of Pharmacy, University of South Carolina speaking on "The Economic Impact of Aids." *Staff photo.*

Two hundred eighty-four seminar registrants were in attendance at the Holiday Inn Four Seasons in Greensboro. *Staff photo.*

Keith Inman has purchased the Client Pharmacy in Atkinson from Norwood Blanchard of Burgaw. He is anticipating a name change for the pharmacy in the future. Inman is a native of Rockingham and the son of G.G. Inman of Rockingham. He has worked for individual pharmacists and chain stores since he graduated from UNC-CH School of Pharmacy. Inman is married to the former Susan Dail and has two children, Justin, 5, and Paigne, 19 months.

Greg Bower purchased Jefferson Drugs from Dale Shepherd and James Badger. He plans to emphasize the store's line of discount durable medical equipment. Bower, whose wife and two daughters will live in Charlotte until about April, most recently owned a drug store in China Grove. Bower attended the School of Pharmacy at UNC-CH.

Awards, Honors, Citations

Ed Lowdermilk was recently honored by the East Chapel Hill Rotary Club as a Paul Harris Fellow. Paul Harris was the founder of Rotary International and the award that bears his name represents a donation by a local club of $1000 in the name of the recipient to the Rotary Foundation. This particular donation went to the Polio Plus program which is providing Polio immunizations to children worldwide.

Lowdermilk received this award for service to his club and community, including editor of the club newsletter for the past sixteen years and past president of the Heart Association. He is a relief pharmacist in the Chapel Hill area.

Herbert Hollowell, Jr. of Edenton was recently honored as the John A. Mitchner Business Person of the Year.

Steve Dedrick of Durham received the Hospital Pharmacist of the Year by the NC Society of Hospital Pharmacists. Dedrick, associate director of Pharmacy Services at Duke Medical Center, received the organization's highest honor in recognition of his involvement with the Society. He has been a member of the Society for more than 10 years and served two years as president. He is currently chairman of the organizational affairs and convention and planning committees.

Pam Joyner of Morrisville has received the NC Society of Hospital Pharmacists' Award for Continuing Excellence at the group's winter conference in High Point. Joyner is pharmacy education director at the Wake Area Education Center in Raleigh.

Births

Rowdy and **Charlotte Mize** announce the birth of their son, Stuart Reid Mize, born March 15, 1989. Stuart weighed 6 pounds, 12 ounces.

Deaths

Robert Louis "Luke" Irwin, 66, of Elkin died February 20, 1989. Irwin was a graduate of the UNC-CH School of Pharmacy and a co-owner of Elk Pharmacy.

Arthur G. Kiser, 78, of Asheville, died February 19, 1989. Kiser was a UNC-CH School of Pharmacy graduate and co-owner and manager of Montford Pharmacy. He was also a former pharmacist at Highland Hospital.

AFFILIATE NEWS

The **Randolph County Pharmaceutical Society** has joined forces with the Randolph Senior Adults Association, RCSAA, to offer the older population a very useful opportunity. Area pharmacists have volunteered their time to visit RCSAA locations to counsel one-on-one with older adults about the medicines they are currently taking. Each older adult wishing to participate will be asked to "Bag Up" all of their prescriptions and over-the-counter drugs they are currently using. Kim Stutts, pharmacist at the Fayetteville Street Revco and Martha Clock are the program coordinators.

PCS OPENS RECAP℠ NETWORK TO OTHER VENDORS

PCS announced that effective April 1, 1989, stand alone certified Point of Sale (POS) terminal vendors will be granted access to the PCS Recap℠ network, an on-line electronic prescription drug claim processing system.

PCS also announced that it is in the process of upgrading current Recap pharmacy terminals. PCS Recap terminals will have the capability to submit on-line claims to other processors. PCS indicated that the company is currently negotiating with claim processors to assure timely service for all users.

Welcome New Members!

Daria Anne Wuycik, Lexington
Donna M. Maxwell, Carrboro
Patricia Boone Buehner, Raleigh
Hobson Ivan Gattis Jr., Raleigh
Barbara B. Hankins, Charlotte
Mary Ann Largen, Charlotte
Edwin Link, Wilmington
Kathryn A. Rhyne, Raleigh

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In a Convenience Pak survey (N = 100)[1]

- 100% said the directions on the Convenience Pak were clear and easy to understand
- 93% reported not missing any doses

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The Convenience Pak promotes patient counseling

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Convenience Pak is available at no extra cost

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1. Data on file, Lilly Research Laboratories

NZ-2907-R-942310

AXID®

nizatidine capsules

Brief Summary
Consult the package literature for complete information.

Indications and Usage: Axid is indicated for up to eight weeks for the treatment of active duodenal ulcer. In most patients, the ulcer will heal within four weeks.

Axid is indicated for maintenance therapy for duodenal ulcer patients at a reduced dosage of 150 mg h.s. after healing of an active duodenal ulcer. The consequences of continuous therapy with Axid for longer than one year are not known.

Contraindication: Axid is contraindicated in patients with known hypersensitivity to the drug and should be used with caution in patients with hypersensitivity to other H_2-receptor antagonists.

Precautions: *General* — 1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Because nizatidine is excreted primarily by the kidney, dosage should be reduced in patients with moderate to severe renal insufficiency.

3. Pharmacokinetic studies in patients with hepatorenal syndrome have not been done. Part of the dose of nizatidine is metabolized in the liver. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests — False-positive tests for urobilinogen with Multistix® may occur during therapy with nizatidine.

Drug Interactions — No interactions have been observed between Axid and theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450-linked drug-metabolizing enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increases in serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility — A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice; although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a two-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy — Teratogenic Effects — Pregnancy Category C — Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus and at 50 mg/kg it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers — Studies conducted in lactating women have shown that < 0.1% of the administered oral dose of nizatidine is secreted in human milk in proportion to plasma concentrations. Caution should be exercised when administering nizatidine to a nursing mother.

Pediatric Use — Safety and effectiveness in children have not been established.

Use in Elderly Patients — Ulcer healing rates in elderly patients are similar to those in younger age groups. The incidence rates of adverse events and laboratory test abnormalities are also similar to those seen in other age groups. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of nizatidine included almost 5,000 patients given nizatidine in studies of varying durations. Domestic placebo-controlled trials included over 1,900 patients given nizatidine and over 1,300 given placebo. Among reported adverse events in the domestic placebo-controlled trials, sweating (1% vs 0.2%), urticaria (0.5% vs < 0.01%), and somnolence (2.4% vs 1.3%) were significantly more common in the nizatidine group. A variety of less common events was also reported; it was not possible to determine whether these were caused by nizatidine.

Hepatic — Hepatocellular injury, evidenced by elevated liver enzyme tests (SGOT [AST], SGPT [ALT], or alkaline phosphatase), occurred in some patients and was possibly or probably related to nizatidine. In some cases, there was marked elevation of SGOT, SGPT enzymes (greater than 500 IU/L) and, in a single instance, SGPT was greater than 2,000 IU/L. The overall rate of occurrences of elevated liver enzymes and elevations to three times the upper limit of normal, however, did not significantly differ from the rate of liver enzyme abnormalities in placebo-treated patients. All abnormalities were reversible after discontinuation of Axid.

Cardiovascular — In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

CNS — Rare cases of reversible mental confusion have been reported.

Endocrine — Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to Axid. Impotence and decreased libido were reported with equal frequency by patients who received Axid and by those given placebo. Rare reports of gynecomastia occurred.

Hematologic — Fatal thrombocytopenia was reported in a patient who was treated with Axid and another H_2-receptor antagonist. On previous occasions, this patient had experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental — Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity — As with other H_2-receptor antagonists, rare cases of anaphylaxis following administration of nizatidine have been reported. Because cross-sensitivity in this class of compounds has been observed, H_2-receptor antagonists should not be administered to individuals with a history of previous hypersensitivity to these agents. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other — Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine administration have been reported.

Overdosage: Overdoses of Axid have been reported rarely. The following is provided to serve as a guide should such an overdose be encountered.

Signs and Symptoms — There is little clinical experience with overdosage of Axid in humans. Test animals that received large doses of nizatidine have exhibited cholinergic-type effects, including lacrimation, salivation, emesis, miosis, and diarrhea. Single oral doses of 800 mg/kg in dogs and of 1,200 mg/kg in monkeys were not lethal. Intravenous median lethal doses in the rat and mouse were 301 mg/kg and 232 mg/kg respectively.

Treatment — To obtain up-to-date information about the treatment of overdose, a good resource is your certified regional Poison Control Center. Telephone numbers of certified poison control centers are listed in the *Physicians' Desk Reference (PDR)*. In managing overdosage, consider the possibility of multiple drug overdoses, interaction among drugs, and unusual drug kinetics in your patient.

If overdosage occurs, use of activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance.

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Additional information available to the profession on request.

Axid® (nizatidine, Lilly)

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PharmaDates
1989

May 1-2—NARD 21st Annual Conference on National Legislation & Public Affairs, Washington, D.C.
May 4-5—NCPhA National Legislative Committee Meeting, Institute of Pharmacy
May 8-9—National Council on Patient Information and Education 7th Annual Conference on Prescription Medicine Information and Education, Washington, D.C.
May 15—Board of Pharmacy Reciprocity Examination, The Carolina Inn
May 16—Board of Pharmacy Meeting, Board of Pharmacy
May 17-20—NCPhA Annual Convention, North Myrtle Beach, SC
May 21—*NCPhA/NCSHP Seminar, North Myrtle Beach, SC
June 4-8—ASHP Annual Meeting, Nashville, TN
June 20—Board of Pharmacy Meeting, Board of Pharmacy
June 26-27—Board of Pharmacy Licensure Examination, UNC School of Pharmacy
July 17—Board of Pharmacy Reciprocity Examination, Institute of Pharmacy
July 18—Board of Pharmacy Meeting, Board of Pharmacy
August 14—Board of Pharmacy Reciprocity Examination, Institute of Pharmacy
August 15—Board of Pharmacy Meeting, Board of Pharmacy
September 18—Board of Pharmacy Reciprocity Examination, Institute of Pharmacy
September 19—Board of Pharmacy Meeting, Board of Pharmacy
September 20-21—NCSHP Fall Seminar, Greensboro
October 16—Board of Pharmacy Reciprocity Examination, Institute of Pharmacy
October 17—Board of Pharmacy Meeting, Board of Pharmacy
November 20—Board of Pharmacy Reciprocity Examination, Institute of Pharmacy
November 21—Board of Pharmacy Meeting, Board of Pharmacy
December—ASHP Midyear Clinical Meeting, Atlanta, Georgia

**Note: The NCPhA/NCSHP Seminar was previously scheduled on Wednesday, May 17, 1989; it has been changed to Sunday, May 21, 1989.*

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THE NORTH CAROLINA PHARMACEUTICAL ASSOCIATION BEACH CONVENTION VACATION

North Myrtle Beach Hilton, South Carolina
109th Annual Convention
May 17-21, 1989
Convention-in-Brief

Wednesday, May 17

3:00 p.m.-6:00 p.m.	Registration *Main Lobby*
6:00 p.m.	PRESIDENTS' RECEPTION honoring the Presidents of NCPhA, the Woman's Auxiliary & the Traveling Member's Auxiliary *Pool Terrace*
7:00 p.m.	*OPENING SESSION BANQUET — Master of Ceremonies, President Al Lockamy, Jr.; featured speaker, Robert H. Henry presenting, "Win With A.C.E.S., Attitude & Ambition, Commitment, Enthusiasm and Service" followed by Award presentations *Center Ballroom*

Thursday, May 18

7:00 a.m.	Woman's Auxiliary Beach Walk-A-Thon (Everyone is invited to participate.)
7:30 a.m.	T.M.A. Foundation Auxiliary Breakfast *Staff Conference Room*
7:30 a.m.	V.I.P. Breakfast *West Ballroom*
8:00 a.m.-1:00 p.m.	Registration *Main Lobby*
9:00 a.m.	**1st NCPhA BUSINESS SESSION — President-Elect, Ralph H. Ashworth, presiding. Rite of the Roses conducted by Third Vice President, Mr. Robert W. Worley and Mrs. Robert W. Worley; President's Address; Schools of Pharmacy Reports; CE Program: "Legal Issues Associated With Expanded Roles For Pharmacists With Regard To Patient Services" presented by Walter Fitzgerald, J.D., Executive Director and General Counsel, American College of Apothecaries *East Ballroom*
10:30 a.m.	Woman's Auxiliary Brunch and Fashion Show by Myrtle Beach's *Victoria's Ragpatch.* **Sponsored by Glaxo, Inc.** *South Deck*
12:30 p.m.	Campbell University and UNC Schools of Pharmacy Preceptors' Luncheon *Parlours I-IV*
12:30 p.m.	Woman's Auxiliary Shopping Spree at Pawley's Island
1:00 p.m.	GOLF & TENNIS TOURNAMENTS — **Golf sponsored by Owens Brockway, Co-Chairmen, Junior Little & Mike Joyner; Carts by Burroughs Wellcome Co.; Tennis sponsored by Jefferson Pilot, Co-Chairmen, G.N. (Jerry) Brunson & Sam Stuart**
9:00 p.m.-midnight	T.M.A. Dance featuring *THE EMBERS*; cash bar. **Sponsored by the Traveling Member's Auxiliary** *Center Ballroom*

Friday, May 19

7:00 a.m.	*PharmPAC Breakfast (Everyone is welcome.) *Alfredo's*
8:00 a.m.-1:00 p.m.	Registration *Main Lobby*

8:30 a.m.	Woman's Auxiliary Coffee *Hospitality Room 402*
9:00 a.m.	**2nd NCPhA BUSINESS SESSION — Second Vice President, J. Frank Burton, Jr., presiding. CE DAY, Program 1: Cholesterol Education Program by Kirk Ways, M.D., East Carolina School of Medicine, Department of Endocrinology. Program 2: "Managing Your Pharmacy's Financial Health" by Jean P. Gagnon, Ph.D., Director of Pharmacy Relations, Marion Laboratories *East Ballroom*
9:30 a.m.	Woman's Auxiliary Business Session *West Ballroom*
11:00 a.m.	Traveling Member's Auxiliary Business Session *Parlours I-IV*
12:00 p.m.	Woman's Auxiliary Luncheon featuring *The First Resort*, A Sweet Adelines Barbershop Quartet. **Sponsored by Burroughs Wellcome Co.** Installation of Officers will follow the luncheon. *Another World*
12:00 p.m-1:00 p.m.	Complimentary lunch for Exhibitors in *The Exhibit Hall*
1:00 p.m.-6:00 p.m.	EXHIBITORS FAIR AND LUNCHEON *The Exhibit Hall*
11:00 p.m.	ICE BOX RAID/DESSERT RECEPTION *Pool Terrace*

Saturday, May 20

7:30 a.m.	*1939 Class Reunion Breakfast *Parlours I-IV*
7:30 a.m.	*Christian Pharmacists' Breakfast *Another World*
8:00 a.m.-12:30 p.m.	Registration *Main Lobby*
9:00 a.m.	**3rd NCPhA BUSINESS SESSION — President Al Lockamy, Jr., presiding. Annual Salary Survey presented by Jan Phillips, Ph.D.; NCPhA Committee Reports; Nominations of NCPhA 1990-91 Officers; Executive Director's Report *East Ballroom*
12:30 p.m.	*RECOGNITION LUNCHEON Installation of Officers, Luncheon, 50-Plus Club Inductions and Awards *Center Ballroom*
2:30 p.m.-5:00 p.m.	Academy of Consulting Pharmacists — moderator, Charles Pulliam *Parlours I-IV*
7:00 p.m.	*A NIGHT IN THE ISLANDS featuring a Luau feast and the *Lei Aloha's Polynesian Rainbow Revue Pool Terrace & Deck*

Sunday, May 21

8:00 a.m.	Seminar Registration
9:00 a.m.-3:00 p.m.	SEMINAR: THE PHARMACIST'S ROLE & RESPONSIBILITY IN HEALTH PROMOTION AND DISEASE PREVENTION —Sponsored by NCPhA and NCSHP. Background information on cancer screening and substance abuse recognition and prevention and "how-to" programs for use in your community will be presented. Six contact hours of A.C.P.E. Continuing Education will be provided. Look for details of the seminar program in the mail.

**Reservations for these activities may be purchased through the NCPhA office.*
***All convention registrants are invited to NCPhA's Business Sessions.*

STATE BOARD OF PHARMACY

Members — W. R. Adams, Jr., Wilson; Harold V. Day, Spruce Pine; W. Whitaker Moose, Mount Pleasant; W. H. Randall, Lillington; Evelyn P. Lloyd, Hillsborough; William T. Biggers, Asheville; David R. Work, Executive Director, P.O. Box H, Carrboro, NC 27510.

Telephone # (919) 942-4454

PHARMACY PERMITS ISSUED

Permits Issued 1/16/89

Allen's Discount Drug, Inc.
903 West Vernon Ave.
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Michael C. Allen, ph-mgr.

Caldwell County Health Dept. (LSP)
321 Mulberry St.
Lenoir, NC
Freddie H. Moore, ph-mgr.

Caldwell County Health Dept. (LSP)
24 Falls Ave.
Granite Falls, NC
Freddie H. Moore, ph-mgr.

Iredell County Health Dept. (LSP)
412 East Center Ave.
Mooresville, NC
V. Irving Boyles, Jr., ph-mgr.

Wal-Mart Pharmacy
201 North 321 Bypass
Lincolnton, NC
Sandra W. Hincher, ph-mgr.

Wal-Mart Pharmacy
3005 Claredon Blvd.
New Bern, NC
Delon Dove, ph-mgr.

Wal-Mart Pharmacy
Rt. 5, Box 5
US Hwy. 701 Bypass South
Whiteville, NC
Mike Downing, ph-mgr.

Permits Issued 1/25/89

Clinic Pharmacy (T/O)
Church St.
Atkinson, NC
John K. Inman, ph-mgr.

Permits Issued 1/26/89

Kroger Pharmacy
6300-150 Creedmoor Rd.
Raleigh, NC
Joseph P. Graham, ph-mgr.

BI-LO (T/O)
2651 E. Franklin Blvd.
Gastonia, NC
Julian Emery, ph-mgr.

Jefferson Drug Store (T/O)
Old Hwy. 221
Jefferson, NC
Gregory K. Bower, ph-mgr.

Medicine Shoppe (T/O)
1612 Market St.
Wilmington, NC
Wm. Edwin Link, Jr., ph-mgr.

Permits Issued 2/2/89

Triad Home Therapeutics, Inc. (LSP)
1410-A Millgate Dr.
Winston-Salem, NC
Wm. F. Stewart, ph-mgr.

Permits Issued 2/6/89

Maple Hill Pharmacy (LSO)
Old Maple Hill Rd.
Maple Hill, NC
India B. Hood, ph-mgr.

Permits Issued 2/14/89

North Carolina Home Therapeutics, Inc. (T/O)
1112 Harding Place, Suite 100
Charlotte, NC
Mary Joan Turlington, ph-mgr.

Continued on page 25

GEER

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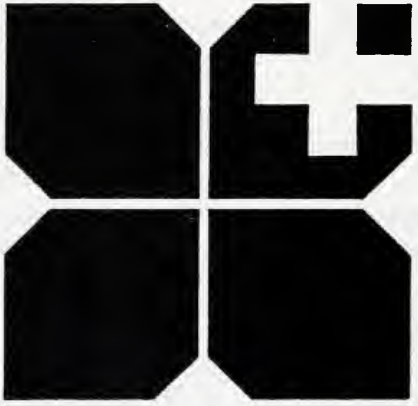

CHARLESTON, S.C.
GREENVILLE, S.C.

PHARMACY PERMITS

Continued from page 23

Permits Issued 2/14/89
Whitakers Pharmacy (T/O)
Railroad St.
Whitakers, NC
M.A. Moore, Jr., ph-mgr.

Permits Issued 2/20/89
Moore Drug Store
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Avery Moore, Jr., ph-mgr.

Permits Issued 2/22/89
Ecker Drugs
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20605 Torrence Chapel Rd.
Cornelius, NC
Benton John Moffett, Jr., ph-mgr.

Permits Issued 3/6/89
BI-LO
7323 E. Independence Blvd.
Charlotte, NC
Joe Cooke, ph-mgr.

Kerr Drug Store
Homestead Market
219 W. Hwy. 54
Durham, NC
Jack Landers, ph-mgr.

Wal-Mart Pharmacy
Huffman Mill Plaza
3141 Garden Rd.
Burlington, NC
James Haywood Gooch, ph-mgr.

Wal-Mart Pharmacy
2099 North Bridge St.
Elkin, NC
Henry Stephen Brown, ph-mgr.

Wal-Mart Pharmacy
303 S. Madison Blvd.
Roxboro, NC
Krista Rayfield DeBrew, ph-mgr.

Permits Issued 3/7/89
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129 W. Mountain St.
Kings Mountain, NC
Harold Arthur Bolick, ph-mgr.

Seagrove Drug (T/O)
Hwy. 220
Seagrove, NC
James W. Cole, ph-mgr.

THE JOINING UP PROCESS

Continued from page 12

just as well as management does. Then management does not have to bring heavy pressure on them to get the needed outcome and they don't have to get their back up to protect their professional autonomy.

Another aspect is giving employees enough contextual information to do their job well. Management is often too secretive, using competitive security as their excuse. When a manager is secretive with me as a consultant, I just let it pass. Then later I find an occasion to ask the manager what he or she knows about their competition in that regard. They usually launch into a gleeful description of what their competition does. Then I point out that, if they know that much about the competition, what makes them think the competition doesn't already know it about them. Then we can get on to giving the employees the data they need to operate effectively and independently. If they have enough contextual data and a good understanding of the contract, they will have little trouble identifying where it has to be improved. They will have little problem knowing what it is they have to do and why. They will be able to make their decisions independently, but in a way that lets their actions move the organization forward constantly.

The successful psychological contracting process:

1. Is at the core of the joining-up process.
2. Includes a wide variety of professional issues.
3. Needs a renegotiation process, best worked into annual reviews.
4. Links to the budgetary process.
5. Must take place in an environment of broad information about the organization and its needs.

References:

[1]Adapted from M.P. Wilson and C.P. McLaughlin, *Leadership and Management in Academic Medicine*, San Francisco: Jossey-Bass, Inc. Publishers, 1984, p. 310.

DICKINSON'S PHARMACY

Patients as pharmacy soldiers. Any politician will tell you that the public is fickle, and any retailer who's been left with overstocked merchandise will tend to agree.

Yet no matter how fickle public support for various causes and fads may be, no politician, business or profession can long survive without it. In a democracy, it's the power to move mountains.

For at least the last five years, pharmacists have been either second or first at the top of the scale of public trust. But as pharmacy's myriad daily problems seem to multiply, you might ask: What is that public support really worth?

In the northern California city of Eureka last January, a retired former state employee named Martha Smith set out, against heavy odds, to show that it might be worth a demonstration of blind cost-containment's ability to yield to better health care.

And across the country, in Richmond, Virginia, another member of the public, Joan Dent (secretary of the public employees' association), took up the same pro-pharmacy cause with the help of a registered nurse who had received a drug mix-up in the mail.

Neither woman's fight was over when this column went to press, but their early experiences provide inspiration for the establishment of similar grassroots efforts to overcome managed-care prescription programs that treat the public like pawns in some giant game of che$$.

The obstacles Martha Smith encountered in her campaign were daunting. When presented with a new, financially coercive mail-order drug "option" in her retirees' health programs she decided she simply was not going to be bullied that way.

But although her elderly friends facing the same ultimatum were verbally supportive, when push came to shove, all but four were afraid to get militant enough about it to join Martha in her telephone and letter-writing efforts.

One of Martha's ideas for opposing the coercive program roll-over into mail-order was to survey her local pharmacists—and that's when she ran into her second barrier. Eight out of ten simply did not return the survey questionnaire she and her group distributed—although they were all happy to grumble about mail-order when spoken to directly.

The third obstacle came in the health program's non-responsiveness to their phone calls and letters. Martha decided to enlist the

James G. Dickinson

support of the pharmacy services administrative organization, Pharmaceutical Care Network, who put her in touch with me.

I was able to send her a small mountain of documentation. As Martha went to work with her retirees' association leadership and made contact with state politicians, things slowly began to take a turn for the better.

After "forgetting" and "losing" two months of repeated requests that it supply, under the state sunshine law, a copy of the coercive mail-order contract, Martha finally obtained one in March.

Martha then achieved a breakthrough with the editor of the state retired public employees' association newsletter—a full feature article on the controversy, provoking the admiration of many, including NARD executive vice president Charles M. West: "We totally support the objectives of Martha Smith's network in California which are freedom of choice and comparable safeguards for the consumer."

Now we have the ear of state politicians, retirees, organized pharmacy, and even federal officials. A petition I submitted for FDA regulation of all high-volume mail-order facilities brought an encouraging—and unusual—personal response from FDA Commissioner

Continued on page 27

Dickinson's Pharmacy is a syndicated column that appears monthly in many state pharmaceutical journals across the country. Mr. Dickinson is editor and publisher of Dickinson's FDA and Dickinson's PSAO industry newsletters. He has served as assistant executive director of the American Pharmaceutical Association and Washington bureau chief for Drug Topics. His home is in Morgantown, West Virginia.

Frank E. Young in February, ordering "expeditious" agency review because of "important public health issues" raised in the petition.

Meanwhile, Joan Dent has secured mass-media publicity against her coercive mail-order "option"—in an election year. In March she met with state program officials and warned them her members would tolerate every cost-containment device in the program except the mail-order component—then she issued a news bulletin to those members, urging them to watch for, and report, mail-order mix-ups.

Both Joan and Martha are forward troops in what will be a consumer army to promote public health through better pharmaceutical care.

By using the patient's own support groups and lines of communication, pharmacy in turn may ensure that its concerns are honestly heard by those in positions of power who usually dismiss pharmacy's words as the "voice of economic self-interest."

This feature is presented on a grant from G.D. Searle & Co., in the interests of promoting the open discussion of professional issues in pharmacy. G.D. Searle & Co. accepts no responsibility for the views expressed herein as they are those of the author and not necessarily those of G.D. Searle & Co.

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CORRESPONDENCE COURSE
Advising Consumers on OTC Denture Care Products

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Goals

The goals of this lesson are to:

1. identify various types of OTC denture care products;
2. Discuss the proper use of OTC denture care products; and
3. describe damage that can occur from misusing certain OTC denture care products.

Objectives

At the conclusion of this lesson, participants will be able to:

1. list various OTC products that are available for denture care;
2. explain how denture care products should be correctly used;
3. cite specific restrictions for OTC denture care products;
4. state reasons why specific warning statements are required on denture care products; and
5. identify harmful effects that can result from using denture repair kits and denture relining products.

Consumers are barraged with advertising about items they can purchase over-the-counter to care for their dentures. Many OTC denture care products are safe to use as long as the directions are correctly followed. Others may cause irreparable damage to denture material, anad adverse reactions to the user.

More than 50 million Americans wear dentures. They spent over $305,000,000 on denture care products in 1984. This represented a 7 percent increase in sales over the previous year. However, the value represented less than 1 percent increased sales to pharmacies, the difference attributed to grocery and department stores.

This article describes OTC products used to care for dentures. It discusses their uses and misuses, and provides important advice to endentulous (without teeth) consumers contemplating their purchase.

There are five groups of OTC products promoted for use with dentures or tissues in contact with them; cleansers, adhesives, reliners, repair kits, and topical anesthetics. Cleansers are useful; topical anesthetics are safe and effective for their intended use. But many experts advise against the use of the other three categories of products except on a restricted basis until the denture wearer obtains professional advice.

The information reported in this article reflects the opinions of these experts, which include representatives of the American Dental Association (ADA), and the FDA/OTC advisory panels on oral products.

Cleansers

Denture material collects debris, stains, and plaque just like normal teeth. These can lead to an unsightly appearance and strong odor. Plaque hardens into tartar which irritates the gingiva (gums) and is the beginning of periodontal disease.

Denture cleansers (Table 1) have chemical or abrasive actions. *Chemical* ingredients include detergents, dilute acids, alkaline perioxides and hypocholorites, and chelating agents.

Abrasive pastes or powders are essentially similar to regular toothpaste and powder dentifrice products available for cleaning permanent

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in the service of pharmacy

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CORRESPONDENCE COURSE

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TABLE 1

OTC Dental Cleansers

Product	Manufacturer
Complete	Vicks
Denalan	Whitehall
Denclenz	Creighton
D.O.C.	H.J. Bosworth
Efferdent	Warner-Lambert
Extar	Extar
K.I.K.	K.I.K. Co.
Kleenite	Vicks
Mersene	Colgate-Palmolive
Polident	Block

teeth. In general, powders are more abrasive than pastes.

Denture soaking solutions do not take the place of brushing. They supplement brushing, and serve as a medium to soak the dentures in when they are not being worn. Some cleansing solutions may actually damage dentures. For example, dilute acids may corrode cobalt-chromium denture mateiral. Alkaline hypochlorite cleansers may cause similar corrosive action, and reportedly bleach some others.

Dentures should be removed and soaked in a cleansing solution overnight, and regularly brushed with a mildly abrasive dentifrice. Overnight removal relieves pressure on the gums and allows them to rest and breathe. Without this release, oral tissues can become macerated and eventually degenerate. This, and accumulated plaque, can lead to denture-induced stomatitis (inflammation of the oral mucosa).

Keeping the dentures in a liquid when removed from the mouth reduces their chance of becoming brittle. Also, it prevents shrinkage which can occur with drying.

Denture wearers should not soak dentures in chemical solutions that are not specifically intended for this purpose. Household bleach, vinegar and other acids may aid in removing certain stains and plaque. They may also damage denture material. Most effervescent tablets are to be added to warm, not hot, water to dissolve. Hot water may cause warping of some denture material.

When dentures are brushed, they should be first be rinsed under running water to remove loose debris. A cleansing agent is then applied to a moistened brush, and all parts of the denture thoroughly scrubbed. They should then be adequately rinsed. The ADA recommends that dentures be professionally cleaned at least once a year.

A denture brush should be used to clean dentures rather than a regular toothbrush. These brushes are easy to manipulate and are designed to fit the contour of dentures and reach all areas.

Consumers should be instructed how to properly hold and correctly brush their dentures. They should also be told to avoid vigorous brushing with highly abrasive pastes or powders which may ruin denture material.

All cleansing solutions should be thoroughly removed from dentures before they are replaced in the mouth. Some solutions are intensely caustic and can irritate the oral mucosa. They should also be kept out of the reach of children.

Persistent stains that are not removed by OTC cleansing solutions, or brushing with abrasive pastes, should be evaluated by a dentist. They could represent a weakened area on the denture that may rupture.

Adhesives

Denture adhesives (Table 2) are reported to be the most commonly purchased OTC denture care products. They benefit some individuals by holding dentures snugly in place, especially while eating. But with continued use and in the absence of professional supervision, serious problems may result. These will be explained later.

For years, manufacturers of OTC denture adhesives have advertised that their products permit users to bite into apples or corn-on-the-cob without fear of leaving their teeth imbedded in food when they open their jaws.

TABLE 2

OTC Denture Adhesives

Product	Manufacturer
Brace	Norcliff Thayer
Confident	Block
Corega	Block
Cushion Grip	Plough
Dentrol	Block
Effergrip	Warner-Lambert
Fasteeth	Vicks
Fixodent	Vicks
Klutch	Putnam
Orafix	Norcliff Thayer
Orahesive	Hoyt
Polident Dentu-Grip	Block
Poli-Grip	Block
Rigident	Carter
Secure Seals	J & J
Sea-Bond	Combe
Staze	Commerce
Wernets	Block

The fallacies of these claims are apparent in that continued unsupervised use of dental adhesives can cause serious problems. Furthermore, there is no evidence that a person's chewing ability is improved because his dentures are held firmly.

Denture adhesive products are available as pastes, powders, and film. Commonly used adhesives include karaya gum, gelatin, carboxymethylcellulose, methylcellulose, tragacanth, and ethylene oxide polymers.

These substances work in two ways. They swell when moistened to form a mucilaginous gel. This obliterates spaces between the denture and gums, and secures a tighter fit.

Also, they increase the surface tension coefficient of the fluid film between the denture and its supporting tissues. This causes the prosthesis to be anchored more solidly.

Adhesives are only recommended for temporary use, as an emergency measure to stabilize dentures until the patient can obtain a dental appointment. They can be safely used as long as the individual is under the care of a dentist.

The ADA Council on Dental Materials and Devices passed judgment on adhesive products. Acceptable products include a label warning statement as shown in Table 3.

Some users of dental adhesives report that the products are messy and disagreeable to use. Large amounts of the adhesive may work out from beneath the dentures, especially the lower ones. The adhesive is then expectorated or swallowed. Some people avoid using adhesives on lower dentures for this reason. Denture wearers should be informed that leakage may occur from using too much product.

Other individuals claim that denture adhesives become foul tasting when combined with oral secretions. Adhesive ingredients may serve as culture medium for microbial growth. This can be minimized by removing the dentures, cleaning and rinsing them, and applying fresh adhesive twice daily.

Claims are also made that pastes are somewhat more effective than powders because of their moisture-resistant properties. Clinical studies have so far failed to substantiate these claims.

One major problem with OTC denture adhesives is that the need for additional adhesion increases over time as the patient continues to use the product. This can place uneven stress on underlying bone and soft tissues of the gums and mouth, enhancing their destruction. Serious oral pathology including ulcers and tumors may also develop with chronic use of denture adhesives.

Typically a person begins using an adhesive. Later when more and more adhesion is needed, he switches to a reliner. This can be the beginning of severe problems.

Consumers wishing to use an adhesive until they can see a dentist should be instructed how to correctly use it. To use a powder, a light layer should be sprinkled over a moistened denture before placing in the mouth. For pastes, a light layer should be applied to a dry denture before placing in the mouth.

Because it is not possible to apply the same amount of adhesive each time, there is a potential for the dentures to be constantly repositioned in the mouth. Consumers should try to apply the same amount of adhesive evenly to avoid this.

Denture adhesive seals can eliminate this problem. These consist of a thin film of adhesive that is laid on the denture before placing it in the mouth. The amount of product used is always consistent.

Some individuals may be sensitive to one or more ingredients in denture adhesives. The one most often implicated is karaya. It may cause runny nose, watery eyes, eczema, atopic dermatitis and gastrointestinal distress. If these symptoms appear, another product containing different ingredients should be selected.

Denture adhesive users should not add more product until the first application has been

Continued on page 32

TABLE 3

Warnings Required on Labeling of OTC Denture Care Products

Denture Adhesives
(product name) is acceptable as a temporary measure to provide increased retention of dentures. However, an ill-fitting denture may impair your health—consult your dentist for periodic examination.

Denture Reliners and Cushions
WARNING: For temporary use only. Long-term use of this product may lead to faster bone loss, continuing irritation, sores, and tumors. For use only until a dentist can be seen.

Denture Repair Kits
WARNING: For emergency repairs only. Long-term use of home-repaired dentures may cause faster bone loss, continuing irritation, sores, and tumors. See your dentist without delay.

CORRESPONDENCE COURSE

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removed. To do so may possibly cause malocclusion of the dentures.

Reliners

Denture reliners (Table 4) are used by persons who hope to improve comfort and function of their false teeth. The products are intended to serve two purposes. They help secure loose-fitting dentures, and they provide a cushion to protect sore spots on the gums.

Relining products are available in different forms. They may consist of wax-impregnated gauze pads shaped to fit the denture, or be soft plastic sheets that are applied to the denture and trimmed. Ingredients in reliner products are different from material dentists use for relining, rebasing or refitting dentures.

While they may provide temporary relief, reliners and cushions used over extended periods of time can cause serious repositioning of dentures more severe than that caused by adhesives. They may cause the appliance to warp. Gingivitis, mouth ulcers, and tumors may eventually result.

Improper use of reliners may change a person's chewing efficiency. They may also create speech defects and cause facial wrinkles and aging lines to become accentuated. Bad breath can become intense from decaying food debris, plaque and microbials trapped within the reliner, or the space between the reliner and denture. Bruxism (grinding the teeth) and clenching the jaws together when talking are other problems associated with the use of reliners.

TABLE 4

OTC Dental Relining and Repair Products

Products	Manufacturer
Reliner	
Denturite	Brimms Inc.
Ezo Denture Cushions	Colorado Chemical
Snug Denture Cushions	Mentholatum
Repair	
Plate-Weld	Norcliff Thayer

Oral Cancer. A factor known to cause oral cancer is ill-fitting dentures. Dentures worn by users of OTC relining products are ill-fitting. After the product is applied, they fit even less correctly. Pain is one of the last symptoms of oral cancer to appear. Once pain is experienced, the cancer may be advanced.

The dental literature reports on patients who wore denture reliners, and eventually felt pain, but associated it with loose dentures. In actuality, the irritation was from oral cancer.

A study of 204 patients with oral cancer showed a direct correlation between wearing dentures and the development of cancer. Irritation caused by the dentures occurred in 86 of the persons involved.

Opponents of denture reliners claim that users are sometimes caught in a vicious cycle. They apply a reliner which may initially secure a tighter denture fit and make the appliance more comfortable. But with time, the increased and uneven pressure applied on underlying bone causes it to resorb and shrink. The denture then becomes less snug and less stable. So more reliner is applied. Consequently, more bone is resorbed over time, and the denture becomes even less secure.

Officials of the American Dental Assocaition and the American Pharmaceutical Association disapprove of the availability of dental reliner products for over-the-counter purchase. Spokesmen from these groups agree that these products are not in the public's best interest.

Consumers using reliners continue to wear dentures which should be relined, rebased, refitted or reconstructed by a dentist. Pharmacists should counsel consumers to see their dentists for professional advice. Almost all authorities agree that these products should be used only until professional help can be obtained.

FDA required that the warning statement shown in Table 3 be included in the labeling of denture relining products.

Repair Kits

Broken dentures may be temporarily repaired using one of the repair kits shown in Table 4. Improper repair can cause serious damage to oral tissues by creating rough spots, or placing unnatural pressure against oral tissues and stresses on the denture itself. The individual should contact a dentist as soon as possible to have them permanently repaired.

Topical Analgesics

Occasionally consumers will report their gums or tongue are sore fron dentures rubbing against them. Such minor pain can be treated with the same OTC products that are indicated for toothache.

The FDA/OTC advisory panel that reviewed these items rated 85 to 87 p ercent eugenol (active ingredient of clove oil) as definitely effective, and benzocaine, butacaine, cresol, eugenol (less than 85 percent), phenol and thymol as possibly effective for oral mucosal pain. Of these, benzocaine and butacaine have the best track record for proof of efficacy.

All of these agents are safe for temporary use. Irritation that persists longer than seven days, or worsens, should be evaluated by a dentist, not self-medicated. Representative OTC products that are promoted for relief of pain due to denture irritation are listed in Table 5.

Summary

OTC denture care products are safe and effective when used as directed on their labels. Dentures that do not fit properly or are broken must be refitted or repaired by a dentist.

TABLE 5

OTC Products for Relief of Denture Irritation

Product	Manufacturer	Local Anesthetic
Anbesol	Whitehall	Benzocaine, phenol
Benzodent	Vicks	Benzocaine, eugenol
Butyn	Abbott	Butacaine
Chloraseptic gel	Proctor & Gamble	Phenol
Kank-a	Blistex	Benzocaine
Numzident	Purepac	Benzocaine, eugenol
Orabase with Benzocaine	Hoyt Labs	Benzocaine
Orajel	Commerce	Benzocaine
Rid-A-Pain	Pfeiffer	Benzocaine

Correspondence Course Quiz

Denture Care Products

1. The proper method for using an adhesive paste is to apply it to:
   a. dry dentures.
   b. moistened dentures.

2. When dentures irritate the gums and cause inflammation, the condition is referred to as:
   a. chelitis.
   b. dentitis.
   c. gingivitis.
   d. stomatitis.

3. When placed in solution, dentrifice products containing peroxides and hypochlorites are:
   a. acidic.
   b. alkaline.

4. The active ingredient that is most commonly included in OTC products intended to relieve denture irritation is:
   a. eugenol.
   b. butacaine.
   c. phenol.
   d. benzocaine.

5. Which of the following OTC denture care products contains this warning in its labeling: *"For temporary use only. Long-term use of this product may lead to faster bone loss, continuing irritation, sores and tumors. For use only until a dentist can be seen."*
   a. Denture repair kits.
   b. Denture adhesives.
   c. Denture reliners.

6. As a general rule, which of the following are more abrasive?
   a. Pastes.
   b. Powders.

7. The term bruxism refers to:
   a. bad breath.
   b. excessive plaque formation.
   c. grinding of the teeth.
   d. speech defect.

8. The proper method of using an adhesive powder is to apply it to:
   a. dry dentures.
   b. moistened dentures.

9. The active ingredient in Chloraseptic gel is:
   a. eugenol.
   b. butacaine.
   c. phenol.
   d. benzocaine.

10. Denture adhesive products secure a tight fit because they exert which of the following physical effects between the denture and its supporting tissues?
    a. Increased surface tension coefficient.
    b. Decreased surface tension coefficient.

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State pharmacy leaders represent NC at NARD's annual National Independent Pharmacy Forum. Whitaker Moose of Mount Pleasant, NARD 2nd Vice President (center) and Al Mebane, III of Chapel Hill, Executive Director, NCPhA, (right) attended the conference. Pictured with them is Charles West, NARD Executive Vice President. See also page 6.

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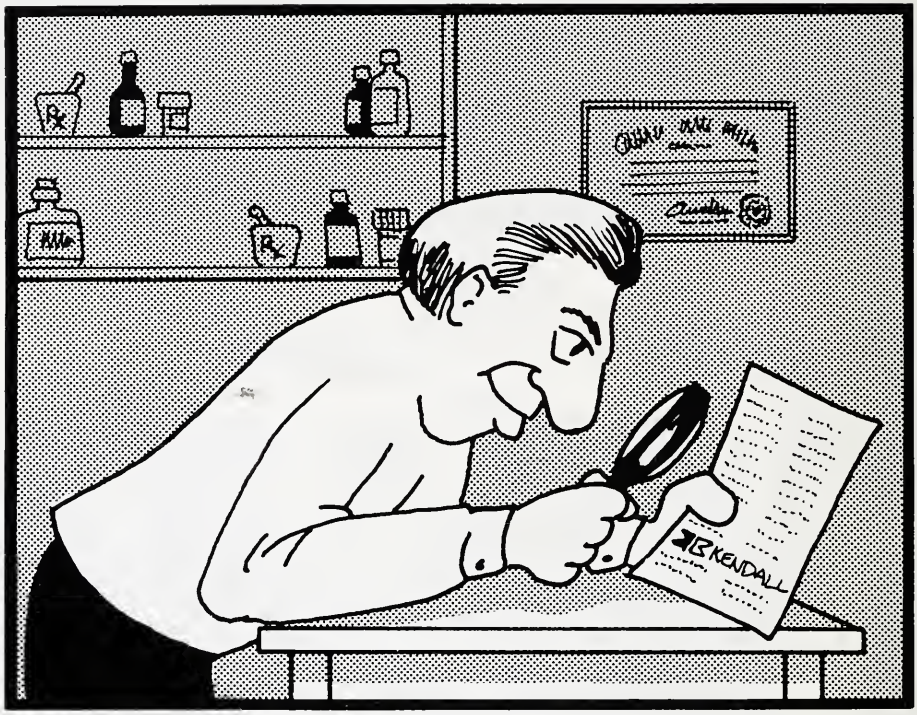

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PRESIDENT'S REMARKS

This is the last time I will have an opportunity to address you in this column as NCPhA president. Since we have received so many favorable comments this year about the president's column Ralph Ashworth will continue the President's Remarks after he takes over as president at the NCPhA Annual Convention in May.

Instead of winding down these past few months as my term as your president, I have continued to be extremely busy. I would like to share with you now some of my experiences as I have traveled near and far during these last months in office.

In February I attended the 23rd Annual Seminar on Socio-Economic Aspects of Pharmacy Practice sponsored by NCPhA and the UNC School of Pharmacy at the Holiday Inn Four Seasons in Greensboro. Despite the 6 inches of snow that day, 300 pharmacists attended this meeting. Many thanks to all of you who braved the snow to support our seminar.

I also attended the First Annual Pharmacy Career Day at Campbell University in February to address high school students interested in pharmacy as a profession. Based on my experience as a practicing community pharmacist for 25 years, I tried to impress upon these students that community pharmacy is not a "9 to 5" profession. Pharmacists have many professional obligations outside their work environment; for example, we must continually update our professional knowledge by reading and attending continuing education seminars. I told them what an important contribution community pharmacists make as a member of the health care team. We are a "gate keeper" to health care. We are always accessible and willing to listen. And lastly, I told them that today's community pharmacist is a health care communicator as we are the provider of drug information to our patients.

Others who participated in the program, including the focus of their presentations, were:

Steve Dedrick, Associate Director, Duke Medical Center, "Hospital Pharmacy in a Medical Center"

James Anderson, Pharmacy Sciences Liaison, The Upjohn Company, "Pharmacy Relations in Industry"

Julian Baker, Director of Pharmacy, Cherry Hospital, "Hospital Pharmacy in a Specialty Hospital"

Benny Ridout, Division of Medical Assistance, NC Department of Human Resources, "Governmental Pharmacy"

Daniel Teat, Director of Admissions and Continuing Education, Campbell University School of Pharmacy, "Planning Your Future"

Kathryn Bucci, Assistant Clinical Professor of Community and Family Medicine, Duke Medical Center, "Clinical Pharmacy"

The month of April was especially busy for me. I was so over booked with appointments as my appointment secretary (me) goofed. My wife, Ginger, kindly agreed to help me out by serving as a panel member at the NC Substance Abuse Conference sponsored by the NC Association of Classroom Teachers. Mrs. James Martin, First Lady of our state, was the keynote speaker. I am glad to see Mrs. Martin taking an active role in combatting drug abuse in our homes, schools, communities, businesses and media.

My family and I traveled to Anaheim for the 136th Annual APHA Meeting, April 8-12. During the Annual Meeting, the APhA House of Delegates adopted a broad range of new policies including support of pharmacy-based screening and monitoring services and opposition to federally-mandated

Continued on page 6

PRESIDENT'S REMARKS

Continued from page 5

multiple-copy prescription order programs. An extensive review and complete list of APhA policies will be featured in an upcoming issue (possibly July) of *American Pharmacy.*

I would like to thank Bill Edmondson, Steve Caiola, and John and Lori Setzer for representing NC as our delegates during the APhA Annual Meeting.

I was very impressed with the number of students from NC who journeyed so far to participate in the APhA Annual Meeting. Since so many enthusiastic students from NC attended the meeting, NCPhA is considering starting a Youth Program during the NCPhA Annual Convention.

On April 28, I journeyed to Washington, D.C. to attend the 21st Annual Conference on National Legislation and Public Affairs sponsored by NARD. This year's meeting focused on the threat to pharmacists posted by discriminatory pricing, especially multitier pricing practices of manufacturers. During the meeting, comprehensive legislation on these practices was developed. A special legislative task force (NARD, NACDS, and APhA) has also been established on price discrimination legislation. The ultimate goal is to guarantee equal access for retail pharmacy and its consumers to prices for similar pharmaceutical goods and products on the same terms as other purchasers in the market place.

In closing, I would like to thank all the pharmacists who supported our profession by attending the Superior Court hearing on the *NC Board of Pharmacy vs Charlotte Memorial Hospital* in Raleigh on April 6. Please read the details concerning the hearing on page 7 of this journal issue.

You may also like to know that plans are already underway for expanding NC Pharmacy Week in October. This year, NC Pharmacy Week will be a joint venture between NCPhA, NCSHP, both Schools of Pharmacy, the pharmacy AHECs, and Industry. Details will be presented at the NCPhA Convention at Myrtle Beach, May 17-21.

Finally, I would like to thank all of you for your support this past year. It has been a pleasure and an honor to serve you as President of NCPhA.

I look forward to seeing you at the 109th Annual Meeting of NCPhA in Myrtle Beach.

Al Lockamy, Jr.
President, NCPhA

Cover photo: Each year NARD gathers members of its 8 steering committees for the National Independent Pharmacy Forum in the nation's capital. The purpose of the conference is to discuss pharmacy issues and to make recommendations for NARD policies and programs that are reviewed by NARD's eight, 50-member standing committees and then considered by NARD's House of Delegates at the association's Annual Meeting. The conference was held February 16-18, 1989 in Washington, D.C. NARD's Annual Meeting will be held this year on November 12-16 in San Antonio, Texas.

JUDGE RULES BOARD OF PHARMACY HAS JURISDICTION OVER HOSPITAL PHARMACIES

On April 12, 1989, Wake County Superior Court Judge Donald W. Stephens ruled that Charlotte-Mecklenberg Hospital Authority/ Charlotte Memorial Hospital and Medical Center, Inc.'s pharmacy is subject to discipline by the NC Board of Pharmacy. Memorial asked for the ruling in January, arguing that only the NC Department of Human Resources' Division of Facility Services, which licenses hospitals, has jurisdiction over the hospital pharmacy.

An attorney representing each state association asked to appear before the court, along with attorneys for the NC Board of Pharmacy at the April 6 hearing, to provide support for the Board's position. Attorney, Gary Whaley of Durham, represented the North Carolina Pharmaceutical Association (NCPhA) at the hearing. Nearly 100 pharmacists from around the state also attended the hearing to show their support of the Board's position.

The hospital's petition was based on a perceived conflict between the hospital licensure granted to the Division of Facility Services and the laws governing hospital pharmacy permits granted to the Board of Pharmacy. Should the Board have the power to remove a hospital permit, argued the Charlotte hospital attorney during the hearing, the hospital would have to close its doors as pharmaceuticals and pharmacists are essential to the hospital. Attorneys for the Board responded that it was clearly the intent of the legislature in revising the Pharmacy Practice in 1981 to have hospital pharmacies under the control of the Board of Pharmacy. The point was made that there was no real conflict since, if a hospital pharmacy permit were rescinded, there are companies who could provide hospital pharmacy services on a contractual arrangement.

Patrice Solberg, attorney for the North Carolina Society of Hospital Pharmacists (NCSHP) pointed out that it would be inappropriate for the hospital administration to make decisions about how pharmacy services are provided, but not be accountable through the possible revocation of the pharmacy permit. Gary Whaley added that the hallmark of a profession is self-regulation.

The events leading up to the judicial review are detailed in the amicus curiae briefs*—on the following page—which were submitted to the court by the NCPhA and the NCSHP. Judge Stephens' decision follows the briefs. (Amicus curiae briefs were also submitted by the Attorney General's office and the NC Hospital Association on behalf of the NC Division of Facility Services.)

It is anticipated that Memorial will appeal the judge's decision to the Court of Appeals. Should this occur, NCPhA will be ready to join the Board again in the fight to preserve the practice of pharmacy in North Carolina. NCPhA members will be alerted if this case progresses any further.

In the meantime, the Board plans to reschedule a hearing on its charges that Memorial's pharmacy and its former director of pharmacy, Wayne Rinehart, were negligent in the deaths of three patients in 1988. David Work, Executive Director, NC Board of Pharmacy, said a hearing could be held on May 16 at the earliest. The Board could reprimand the hospital, or it could suspend or revoke the pharmacy's permit or Rinehart's pharmacist license.

The charges against Memorial stem from the deaths of two heart surgery patients in early 1988 and a third patient in June as reported in the *Charlotte Observer* on April 13, 1989.

William Amick of Rock Hill and Dillon Murphy of Lenoir died after a hyperalimentation solution was allegedly pumped into their hearts instead of cardioplegia solution during surgery. The hyperalimentation solution was mistakenly sent to the operating room because the two medications had been packaged similarly and stored near each other in the pharmacy refrigerator. Since the incident, they have been separated and labeled with color codes.

In the third case, Martha Alice Covert of Concord died after she was reportedly injected with a hydrochloric acid solution about 10 times stronger than her doctor's order. Pharmacists were confused by a handwritten note on the acid container and on the recipe card containing the acid formula.

Ed Frenier, who took over as Memorial's pharmacy director in February, said that the pharmacy now requires two pharmacists to double check each recipe card and has reclarified the pharmacy's policy which forbids handwritten notes on bottles of stock solutions.

NCPhA feels that *The Charlotte-Mecklenberg Hospital Authority/Charlotte Memorial Hospital and Medical Center, Inc. vs. The North Carolina Board of Pharmacy* is a "landmark" case for several reasons:

Continued on page 8

PHARMACY JURISDICTION

Continued from page 7

a) The Board of Pharmacy has been successful in preventing others outside the profession from encroaching into pharmacy's professional prerogatives.
b) The NC Pharmacy Practice Act has withstood opposition and has been upheld as a viable document.
c) The judge's decision reinforces the right of the profession of pharmacy to control pharmacy services at a practice site.
d) The judge's decision preserves the integrity of the profession by maintaining the profession has the right to regulate itself—not just certain segments of the profession.

Together with the Board of Pharmacy and NCSHP, NCPhA has been successful in preventing others from weakening our profession. Once again, NCPhA is doing its part to preserve the practice of pharmacy in North Carolina.

BRIEF OF AMICUS CURIAE NORTH CAROLINA PHARMACEUCTICAL ASSOCIATION IN SUPPORT OF THE NC BOARD OF PHARMACY

STATEMENT OF THE CASE

In presenting its brief to the Court, the North Carolina Pharmaceutical Association (NCPhA) adopts the Respondent's Statement of the Case.

STATEMENT OF FACTS

In presenting its brief to the Court, the NCPhA adopts the Respondent's Statement of Facts.

ARGUMENT

I. HOSPITAL PHARMACIES ARE SUBJECT TO REVIEW AND DISCIPLINARY ACTION BY THE NORTH CAROLINA BOARD OF PHARMACY.

In order to determine the authority that has been bestowed upon any administrative agency one must first look to the statute. The issue in the case at bar is the extent of authority the North Carolina Board of Pharmacy (Board) has over hospital pharmacies. To determine our answer we need to look to The North Carolina Pharmacy Practice Act (the Act) located in Chapter 90 of the General Statutes.

The definition section of The Act is of paramount importance, as this case may well turn on the definition of pharmacy. " 'Pharmacy' means *any place* where prescription drugs are dispensed or compounded." N.C.G.S. Sec. 990-85.3(q) (emphasis added).

Further, because the case at bar involves a hearing on the actions of the management of a pharmacy, and the discipline may involve actions as to a permit or license, it is essential to understand the distinction between the two. A license, "means a license to practice pharmacy including a renewal license issued by the Board." N.C.G.S. Sec. 90-85.3(l). A *pharmacist* is a *person* who is licensed to practice pharmacy under this Article. N.C.G.S. Sec. 90-85.3(p). Both a pharmacist and license deals with a person, not a place. A pharmacist is licensed to practice pharmacy. On the other hand, a permit, "means to operate a pharmacy or dispense devices, including a renewal license issued by the Board." N.C.G.S. Sec. 90-85.3(m) Notice a permit is to *operate* a pharmacy, and a pharmacy is *any place* where prescription drugs are dispensed or compounded. A pharmacy is "permitted" to operate.

These statutory definitions are unambiguous and leave no room for judicial construction. Yet, in its amicus brief, the North Carolina Hospital Association has attempted to confuse the Court by implying that a permit is issued to a pharmacist-manager (license) and not a facility or place. Nothing could be further from the truth. A permit is issued to a pharmacy; a place. In order to obtain a permit, there must be a responsible person in that pharmacy; the pharmacist-manager. The pharmacist-manager's name does go on the permit to show who is in charge. 21 NCAC 46.1601(9). Should the pharmacist-manager cease practice with that pharmacy, he/she must notify the Board and another pharmacist-manager must be appointed. The permit number shall remain the same. The intent is to ensure that no pharmacy is permitted to exist without a licensed pharmacist supervising the facility.

These distinctions are important because N.C.G.S. Sec. 90-85.38(b) provides that, "the Board, in accordance with Chapter 150A of the General Statutes, may suspend, revoke, or refuse to grant or renew any *permit* for the same conduct as stated in subsection (a)." Subsection (a) is a list

of nine reasons why the Board may issue a letter of reprimand or suspend, restrict, revoke, or refuse to grant or renew a *license*. If there were no difference, there would be no reason to have a subsection (a) *and* subsection (b). Clearly there is a difference, a permit deals with a pharmacy, a place; whereas a license deals with a pharmacist, an individual.

Petitioner has made the point several times that the Board can discipline individuals, but not the facility. It has attempted to do so by stating there is simply no authority for the Board to so act, and that licensees and permittees are one and the same. Carrying that to its logical conclusion, the Board could not discipline the pharmacies located in K-Mart, Krogers, Revco or the independent pharmacy located on the corner in our North Carolina towns. This is an absurd result which would have disastrous consequences for the health and welfare of the citizens of our state and which was clearly not intended by our legislature.

To illustrate the necessity for inspecting the pharmacy and the management of the pharmacy, one needs only to look to Charlotte Memorial Hospital. In an unrelated case, after having been informed that a pharmacist was practicing pharmacy after his license had expired, the Charlotte Memorial Hospital Pharmacy took no action to see that the matter was corrected. On September 9, 1987 the *pharmacy* was reprimanded by the Board for its lack of action. See attached Exhibit A. Incidentally the Charlotte Memorial Hospital did not contest the authority of the Board in that action.

In the alternative, Petitioner has presented the argument that although the Board may discipline the retail pharmacies, the act does not apply to hospital pharmacies, because the Department of Human Resources has exclusive jurisdiction over the discipline of hospital pharmacies. Again it is important to carefully read the definitions provided in the Pharmacy Practice Act. A "pharmacy" means *any* place where prescription drugs are dispensed or compounded. The General Assembly did not state that a pharmacy was a retail place, but rather *any* place and that is what it intended. Had the legislature wanted to exclude hospital pharmacies, it would have so stated. Petitioners have cited the result of the case of *Missouri Hospital Association v. Missouri Department of Consumer Affairs, Regulation and Licensing*, 731 S.W.2d 262 (Mo. Ct. App. 1987), as support for its case. However, the Missouri statute did refer to retail pharmacies, unlike the broad definition in North Carolina. It is clear any place *means* any place, and hospital pharmacies are subject to discipline by the Board. The exclusive jurisdiction requested by Petitioner must be given expressly by the General Assembly. In this case the General Assembly gave no such exclusive jurisdiction.

Similarly, as Respondent has so aptly addressed for the Court, the hospital food service must comply with state and local regulations concerning health and cleanliness and x-ray technicians must comply with federal, state and local environmental and safety regulations. Therefore it is not inconsistent for a hospital pharmacy to comply with Board of Pharmacy regulations.

Further, as the North Carolina Hospital Association in its amicus brief has acknowledged, the regulations promulgated by the Facility Services division of the Department of Human Resources, require *all* pharmacies in hospitals to be registered with the North Carolina Board of Pharmacy. 10 N.C.A.C. 3C.1301(b). The regulations even give an address for information on the procedures to register. Yet, Petitioners argue that although their pharmacies are required to be permitted by the Board of Pharmacy, they are not required to abide by the rules to retain such permit. This argument is ludicrous. Petitioners can't have it both ways. If they require their pharmacies to be permitted, they certainly must require them to retain such permit.

The Petitioner asserts that the Courts must reconcile the North Carolina Pharmacy Practice Act and the Health Care Facilities and Services Act. Statutes only need to be reconciled when they are in conflict. In the cas at bar there is no reason why hospital pharmacies cannot comply with both statutes. There is no "catch 22" which would require the hospital pharmacy to make a choice of which law to break. The argument that the statutes need reconciliation is simply a red herring used to obscure the plain language of the Pharmacy Practice Act.

Likewise, the Department of Human Resources has highlighted its 40 years of experience in all hospital functions. By the same token, the Board of Pharmacy was created in 1905 and has much more expertise in regulating pharmacies, including hospital pharmacies. The General Assembly wisely bestowed these powers on the North Carolina Board of Pharmacy.

It is truly alarming to imagine the impact on the practice of pharmacy by a decision of the Court that the North Carolina Board of Pharmacy has no jurisdiction to regulate or discipline

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PHARMACY JURISDICTION

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pharmacies or hospital pharmacies. The minimum standards of competency would be in jeopardy, thus endangering our citizens' health, safety and welfare. The legislative findings in enacting the Pharmacy Practice Act recognized these problems.

It should be noted that the idea of the possibility of the revocation of a permit does not necessarily shut down a hospital. A third party pharmacy could provide services for a hospital or some other arrangement to provide services could be possible. Further, there is no indication that the permit would be revoked in this case. A reprimand is a possibility or no action may be taken. The standards of due process apply and the Board may not act on a whim as is implied by Petitioner.

The NCPhA therefore requests that the ruling of the Board be upheld.

II. THE NORTH CAROLINA BOARD OF PHARMACY'S DEFINITION OF INSTITUTIONS PHARMACY IS VALID.

This issue is again as clear as the statutory definition. It is difficult to comprehend how anyone could think that the Board's definition of "Institutional Pharmacy" could be beyond the powers bestowed upon the Board. The statute defines a pharmacy as, *any* place where prescription drugs are dispensed or compounded. How can any Board make a definition of any pharmacy which exceeds the scope of the statutory definition of pharmacy? If anything, the Board has narrowed the definition by recognizing an institutional pharmacy. This issue simply has no merit and should be dismissed.

Again, it is the desire of the NCPhA that this Court uphold the rules and regulations and decision of the Board. The Board's action is the clear intention of our General Assembly and should be upheld by our judiciary.

BRIEF OF AMICUS CURIAE* NORTH CAROLINA SOCIETY OF HOSPITAL PHARMACISTS IN SUPPORT OF THE NC BOARD OF PHARMACY

STATEMENT OF THE FACTS

On January 30, 1988, Mr. William Amick of Rock Hill, South Carolina died at Charlotte Memorial Hospital and Medical Center as a result of receiving the wrong drug during cardiac surgery. On that same date, Mr. Dillon Murphy of Lenoir, North Carolina died at Charlotte Memorial Hospital as a result of receiving the wrong drug during cardiac surgery. In June, 1988, another patient, Martha Alice Covert, died as a result of errors in the pharmacy at Charlotte Memorial Hospital.

These cases are not the only cases involving Charlotte Memorial Hospital and its pharmacy. Approximately one year ago, the Board of Pharmacy disciplined the Petitioners in this matter as a result of their employing unlicensed personnel to practice pharmacy in the hospital pharmacy. The Petitioners at that time did not object to the jurisdiction of the Board of Pharmacy and entered into a consent order concerning the man who was illegally dispensing drugs at the hospital. A search of the civil action index in Mecklenburg County reveals that other incidents involving this facility have occurred.

The Board of Pharmacy conducted an exhaustive investigation of the first two deaths mentioned above. Charlotte Memorial Hospital provided Board of Pharmacy investigators with full access to all pertinent records, witnesses, and even the bags that had contained the fatal drugs administered to the victims. It gave Board investigators full access to the pharmacy area of the hospital. Its lawyers who were fully informed of this investigation never objected or in any way challenged the Board's authority during the investigatory phase. On August 12, 1988, the Board issued a Notice of Hearing concerning the Petitioner's pharmacy permit. Only when it became clear in December, 1988, that the Board would actually consider taking disciplinary action did the Petitioners file their request for stay with the Court. Significantly, the Petitioners are involved in pending ligitation concerning the deaths of these patients. They may understandably be concerned about the effect of the Board's actions on the final result of those cases.

STATEMENT OF THE CASE

This movant agrees with the Statement of the Case contained in the Brief for Respondent.

ARGUMENT

I. THE PHARMACY PRACTICE ACT CLEARLY GIVES THE BOARD JURISDICTION OVER HOSPITAL PHARMACIES.

G.S. Section 90-85.38(a) authorizes the Board to "suspend, revoke, or refuse to grant or renew

any permit . . ." Section 90-85.3 defines a permit as "a permit to operate a pharmacy . . ." Section 90-85.21, entitled Pharmacy Permit, requires every "pharmacy" to register with the Board pursuant to the Board's regulations. Section 90-85.3(q) defines a pharmacy as "any place where prescription drugs are dispensed or compounded." Clearly prescription drugs are dispensed and compounded at the pharmacy maintained by these Petitioners. Also it is clear that the Board of Pharmacy has jurisdiction over this Petitioner. "Where the language of the statute is clear and unambiguous, there is no room for judicial construction and the courts must give it its plain and definite meaning." Strongs North Carolina Index, 3rd ed. Statutes section 5.5 and the numerous cases cited therein.

Petitioners argue that statutes granting the Medical Care Commission authority to license the hospital preclude the Board of Pharmacy from regulating hospital pharmacies. By the same argument the Board of Medical Examiners would have no authority over the doctors on a s staff and the Board of Nursing would have no authority over the nurses on a hospital's staff. Since most of the state's doctors and nurses work in hospitals, the Legislature would have done a vain act when it purported to license doctors and nurses. The courts may not interpret statutes in a manner that defeats the legislative objective. Stevenson v. Durham, 281 NC 300, 188 S.E. 2d 282 (1972).

Petitioners state repeatedly that the Pharmacy Board is attempting to "regulate the hospital." (See e.g. Petitioners Brief, at pg. 13). This is misleading and inaccurate. All of the notices of hearing and Board actions have been directed solely to the hospital's pharmacy. To rule that the Board is exceeding its authority because of the implications of the Board's actions to the hospital at large, would logically demand the result that the Workers Compensation laws, Federal and State Tax laws, Health and Safety Regulations and all other laws that govern one or more aspects of the hospital are not applicable because of the superior jurisdiction of the Medical Care Commission. The courts will not interpret a statute in a manner that leads to absurd results. Re Annexation Ordinance Adopted by Charlotte, etc. 284 NC 442, 202 SE2d 143 (1974).

The Petitioners argue that the Board's ruling could force the closing of the hospital. They state that such a "tragic result" was obviously not the legislature's intent. The real "tragic results" in this case are the sufferings of the families of William Amick, Dillon Murphy, Martha Alice Covert, and of other persons who have been killed or injured due to negligence occurring at that facility.

The Petitioners' argument fails for two reasons. First, the Board of Pharmacy has no authority to and has not attempted to close the hospital. Second, the petitioners concede that the Legislature has given the Medical Care Commission authority to discipline hospitals and thereby may revoke a hospital's license and close it down. Obviously the Legislature does not consider the closing of a hospital to be "tragic" in cases handled by that Commission.

Another statutory argument raised by the petitioners is based on G.S. 90-85.40(g) which states that the Pharmacy Practice act "shall not be construed to prohibit any person from performing an act that person is authorized to perform pursuant to North Carolina Law." They argue that since the hospital is licensed to operate under the licensure laws, the Board of Pharmacy cannot take action concerning the hospital pharmacy. They again miss the point that this Board has not exerted any authority over the entire hospital. It has not attempted to suspend that hospital's license and the hospital will be legally able to function under the licensure statute. There is no other state law that authorizes facilities to provide substandard pharmaceutical services that result in patient injuries and deaths. Therefore, the Pharmacy Practice Act is not prohibiting this hospital from performing acts (i.e. operating the hospital) that they are authorized under other state law to perform.

Another argument posed by the Petitioners is that allowing the Board of Pharmacy to regulate the hospital pharmacy thwarts the purpose of various statutes including the Pharmacy Practice Act. They state that the role of the Board is to regulate "pharmacists." This completely ignores all of the statutory language in Chapter 90 defining "pharmacies," requiring permits for the operation of "pharmacies," authorizing disciplining of those "pharmacies," and requiring "pharmacies" to meet certain notification standards.

The most amazing part of the Petitioners' argument is that the Board has authority over retail pharmacies and not hospital pharmacies. They cite a Missouri case, Missouri Hospital Association v. Missouri Department of Consumer Affairs, Regulation and Licensing, 731 S.W. 2nd 262 (Mo. Ct. App. 1987) as support for that proposition. They decline to mention in their brief, that the Missouri Court was interpreting a statute that repeatedly specifically restricted itself

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PHARMACY JURISDICTION

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to "retail" pharmacies. Our statute has no such restriction. They also failed to mention to the Court that the Missouri case affirmed the Board's authority over hospital pharmacies that sell drugs directly to patients.

Finally, the Petitioners make much of the fact that the Pharmacy Practice Act makes no provision for holding in confidence the names of victims of a hospital's malpractice. It is odd that Petitioners complain of this when it was the Petitioners who first released the names of these patients and the circumstances of their deaths to the Press. See NCSHP Exhibit A.

II. THE PAST INTERPRETATION OF THE PHARMACY PRACTICE ACT BY THE BOARD IS HELPFUL TO THE COURT IN DETERMINING ITS INTERPRETATION.

Since the days of the first pharmacy operated in a North Carolina hospital, the Board of Pharmacy has required the pharmacy to meet standards and obtain a permit. The 1981 revision to the Pharmacy Practice Act did nothing to change this. Significantly, ever since the Petitioners opened their hospital pharmacy, they have applied for permits from the Board. Further, every operating hospital pharmacy in this state has applied for and maintains its hospital pharmacy permit. Now, the Petitioners argue that they were not required to obtain those permits.

Upon the passage of the revised Pharmacy Practice Act, the Board began the development and implementation of its rules that clearly govern hospital pharmacies. Not one hospital objected to those rules on the grounds that this Board had no authority to regulate hospital pharmacies.

Even the Medical Care Commission, who now mysteriously objects to the power of the Board of Pharmacy, enacted T10: 03C.1301(b) which provides that "All pharmacies . . . shall be registered with the North Carolina Board of Pharmacy." It is significant that DHR only mentions this regulation in a footnote of their brief and claims that it is merely a "ministerial act" that they require of their hospitals.

CONCLUSION

Throughout the briefs of the Petitioner and DHR there are references to the "single" error committed by the hospital pharmacy. There was not a "single" error. Three people to our knowledge are dead because of problems with the Petitioner's hospital pharmacy. This pharmacy has a history with the Board of Pharmacy of failing to comply with state laws governing the practice of pharmacy. It boggles the mind that the Medical Care Commission has refused to even conduct a hearing concerning the deaths of these patients. Only when considered in the perspective of the inaction of other affected licensing agencies does the complacency of the Commission seem plausible.

The Petitioners and DHR argue that "the Charlotte area population would be ill-served by an effort of discipline or close the hospital." (Brief of DHR at page 6). Clearly the three deaths already experienced by the "Charlotte area population" are evidenced that these people are being "ill-served" by the complacency of the Medical Care Commission. The North Carolina Board of Pharmacy has taken its job of protecting the public health as a serious mandate from the North Carolina legislature. We can only hope that this Court will see this action for what it really is and will deny the Petitioners' request.

Respectfully submitted this 30th day of March, 1989.

Patrice Solberg
Attorney for NCSHP
PO Box 16157
Chapel Hill, NC 27516
(919) 968-4496

ORDER
Donald W. Stephens, Judge Presiding
Wake County Superior Court
April 12, 1989

THIS MATTER is before the Court on petition of Charlotte-Mecklenburg Hospital Authority and Charlotte Memorial Hospital and Medical Center, Inc., for judicial review of the final agency decision of Respondent North Carolina Board of Pharmacy on Petitioners' request for declaratory rulings. The record discloses that on August 12, 1988, the Pharmacy Board issued a Notice of Hearing, pursuant to Chapter 150B of the General Statutes, for the purpose of conducting a disciplinary hearing to determine whether the Charlotte Memorial Hospital and Medical

Center Pharmacy, holder of pharmacy permit number 119, had been negligent in the practice of pharmacy. The allegations of the Notice of Hearing are that the pharmacy had failed to maintain a system of communicating changes in pharmacy policies, procedures, and products to the personnel employed at the pharmacy. The notice further alleged that this failure by the pharmacy caused the confusion of products stored in the pharmacy and that two patients at Petitioners' hospital died as a result.

Petitioners filed a request for declaratory rulings with the Board in December 1988. The requested rulings were that the North Carolina Pharmacy Practice Act, G.S. §90-85.2, et seq., was not applicable to hospital pharmacies; that the Board's regulation defining institutional pharmacies was invalid to the extent that it purported to apply to hospital pharmacies; and that the Notice of Hearing concerning the pharmacy at Petitioners' hospital should be withdrawn.

The Board issued its declaratory rulings on January 17, 1989, concluding that the Board did have jurisdiction over hospital pharmacies pursuant to the Pharmacy Practice Act, that its rule was therefore valid and that, as a result, the Notice of Hearing should not be withdrawn. Petitioners filed their petition for judicial review, pursuant to G.S.§150B-43, on January 25, 1989. The Honorable Robert L. Farmer entered an order staying operation of the Board's declaratory rulings on January 31, 1989, until the matter could be heard by this court.

This matter was properly calendared for hearing by this court on April 6, 1989. Petitioners and Respondent filed briefs prior to the hearing, as did amicus curiae on behalf of other interested organizations and agencies.

Upon review by the court of the whole record including all briefs filed and the legal arguments presented on behalf of the parties and those presented by the amicus curiae, the court concludes that the North Carolina Board of Pharmacy has authority under G.S. §90-85.2, *et seq.*, to exercise disciplinary jurisdiction over all pharmacies, including hospital pharmacies. The provisions of the North Carolina Pharmacy Practice Act are clear and unambiguous. They are not in conflict with or restricted by any provisions of the Hospital Authorities Act, G.S. §131E-15, *et seq.*, and the Hospital Licensure Act, G.S. 131E-75, *et seq.*. Therefore, the declaratory rulings of the North Carolina Board of Pharmacy issued on January 17, 1989, were correct and within the proper authority of the Board as granted by the legislature.

Wherefore, the final decision of the North Carolina Pharmacy Board dated January 17, 1989; is affirmed. This Petition is dismissed; the stay order entered by Judge Farmer is vacated, and the matter is remanded to the North Carolina Board of Pharmacy to proceed with the disciplinary hearing that is the subject of the August 12, 1988, notice. The Petitioners shall pay the costs.

SO ORDERED on this the 12th day of April 1989.

DONALD W. STEPHENS
JUDGE PRESIDING

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*An *amicus curiae* ("friend of the court") is a person that is not a party to the litigation who volunteers or is invited by the court to give advice upon some pending matter before it. The *amicus curiae brief* contains written arguments and points of fact submitted by the amicus curiae for use in conducting a case.

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PharmaDates
1989

May 15—Board of Pharmacy Reciprocity Examination, The Carolina Inn
May 16—Board of Pharmacy Meeting, Board of Pharmacy
May 17-20—NCPhA Annual Convention, North Myrtle Beach, SC
May 21—*NCPhA/NCSHP Seminar, North Myrtle Beach, SC
June 4-8—ASHP Annual Meeting, Nashville, TN
June 20—Board of Pharmacy Meeting, Board of Pharmacy
June 26-27—Board of Pharmacy Licensure Examination, UNC School of Pharmacy
July 17—Board of Pharmacy Reciprocity Examination, Institute of Pharmacy
July 18—Board of Pharmacy Meeting, Board of Pharmacy
August 14—Board of Pharmacy Reciprocity Examination, Institute of Pharmacy
August 15—Board of Pharmacy Meeting, Board of Pharmacy
September 18—Board of Pharmacy Reciprocity Examination, Institute of Pharmacy
September 19—Board of Pharmacy Meeting, Board of Pharmacy
September 20-21—NCSHP Fall Seminar, Greensboro
October 16—Board of Pharmacy Reciprocity Examination, Institute of Pharmacy
October 17—Board of Pharmacy Meeting, Board of Pharmacy
November 20—Board of Pharmacy Reciprocity Examination, Institute of Pharmacy
November 21—Board of Pharmacy Meeting, Board of Pharmacy
December—ASHP Midyear Clinical Meeting, Atlanta, Georgia

**Note: The NCPhA/NCSHP Seminar was previously scheduled on Wednesday, May 17, 1989; it has been changed to Sunday, May 21, 1989.*

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AROUND THE STATE

In response to the recent Readers' Survey conducted by The Carolina Journal of Pharmacy, this column, featuring news around the state, has been resurrected from the past. The NCPhA staff welcomes your comments and any contributions you wish to make to this column. Photos are also welcome. Send us your news!

In the News

Buchanan's Discount Drug's new post office is getting a lot of attention in South Greensboro. The miniature post office is located in the rear of the drug store in the Alamance Square Shopping Center. Store owners, **Barbara** and **Ronnie Buchanan**, say the store benefits because the post office brings people through the doors. During the Christmas mailing rush, as many as a dozen people sometimes waited in line for stamps and to send packages. The U.S. Postal Service would like to locate "contract stations," such as the Buchanans', in other areas throughout the state.

Harold Bolick has purchased Griffin Drug Store from Chuck Zimmerman in Kings Mountain. Zimmerman purchased the store 4 years ago from Wilson Griffin whose father founded the business. Zimmerman sold the store to Bolick on February 16, 1989 and has moved to Morganton. He operates a drug store in Drexel. Bolick is a 1968 graduate of UNC School of Pharmacy. For the last 8 years he has owned and operated Medifare Drug Store in Earl. Bolick is married to Lucy Arders Bolick and they are parents of a son, Arty Bolick, a sophomore at UNC in Chapel Hill. The family resides in Shelby.

Last year in North Carolina, cocaine claimed at least 44 lives—more than twice as many as in 1987, according to figures released at the University of North Carolina at Chapel Hill in January. Another 12 people died from combinations of cocaine and heroin and 12 more died of heroin alone reported **Dr. Arthur McBay**, chief toxicologist in the Office of the Chief Medical Examiner and professor of pathology and pharmacy at UNC. Total fatalities from illicit drugs jumped from 42 in 1987 to 73 in 1988.

Alvin and **Mona Woody** own and operate Sunwood Pharmacy and Sunwood Medical Professional Services in Statesville. Sunwood Medical Professional Services assists in locating professional personnel to fill vacancies in nursing homes, hospitals and private homes. The company also provides a home health care service. Alvin is a pharmacist and Mona is a registered nurse.

Imasco USA's parent Co., Montreal-based Imasco Ltd., announced in March that its **People's Drug Stores** division would sell 114 of its stores, mostly in Ohio, to Rite Aid Corp. of Shiremanstown, PA. Imasco USA is headquartered in Rocky Mount. Its principal division is the 3,100-unit Hardee's restaurant chain.

Edwin Link recently became the pharmacist and owner of The Medicine Shoppe at 1612 Market St. in Wilmington. Before joining The Medicine Shoppe, Link worked for Eckerd Drugs in Wilmington. He received his B.S. degree in pharmacy from UNC in 1977.

Henrietta L. Lee, a pharmacist for Kerr Drugs in Clayton, was a featured speaker during a program entitled, "Woman in the Workplace: Strategies for Success" sponsored by Mount Olive College on March 7, 1989. Five other area women, including physicians, Drs. Mary Bynum Borgognoni and Ellen T. Brubeck, discussed their careers and the strategies used to achieve their successes. Lee received her B.S. degree from UNC in 1988. She was awarded the Josephus Daniels Scholarship and the Kappa Psi Fraternity Scholarship Award, and was named Outstanding College Student of America.

Since the beginning of this school year, **Michael Cooper** of Lincolnton has spoken to over 1,000 elementary school students on the hazards around their home and things to look for to prevent accidental poisonings. Cooper says he often receive calls from parents that their child may have been poisoned by a household chemical or medicine left around the home. Cooper's concern for the problem led him to inquire about a poison control program sponsored by his employer, Revco Drug. Using materials available through the company, Cooper spreads the word on poison prevention.·

Appointments

William R. "Bill" Long of Hickory has been

Continued on page 21

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Contraindication: Axid is contraindicated in patients with known hypersensitivity to the drug and should be used with caution in patients with hypersensitivity to other H_2-receptor antagonists.

Precautions: *General* — 1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Because nizatidine is excreted primarily by the kidney, dosage should be reduced in patients with moderate to severe renal insufficiency.

3. Pharmacokinetic studies in patients with hepatorenal syndrome have not been done. Part of the dose of nizatidine is metabolized in the liver. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests — False-positive tests for urobilinogen with Multistix® may occur during therapy with nizatidine.

Drug Interactions — No interactions have been observed between Axid and theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450-linked drug-metabolizing enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increases in serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility — A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice; although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a two-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy — Teratogenic Effects — Pregnancy Category C — Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus and at 50 mg/kg it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers — Studies conducted in lactating women have shown that <0.1% of the administered oral dose of nizatidine is secreted in human milk in proportion to plasma concentrations. Caution should be exercised when administering nizatidine to a nursing mother.

Pediatric Use — Safety and effectiveness in children have not been established.

Use in Elderly Patients — Ulcer healing rates in elderly patients are similar to those in younger age groups. The incidence rates of adverse events and laboratory test abnormalities are also similar to those seen in other age groups. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of nizatidine included almost 5,000 patients given nizatidine in studies of varying durations. Domestic placebo-controlled trials included over 1,900 patients given nizatidine and over 1,300 given placebo. Among reported adverse events in the domestic placebo-controlled trials, sweating (1% vs 0.2%), urticaria (0.5% vs < 0.01%), and somnolence (2.4% vs 1.3%) were significantly more common in the nizatidine group. A variety of less common events was also reported; it was not possible to determine whether these were caused by nizatidine.

Hepatic — Hepatocellular injury, evidenced by elevated liver enzyme tests (SGOT [AST], SGPT [ALT], or alkaline phosphatase), occurred in some patients and was possibly or probably related to nizatidine. In some cases, there was marked elevation of SGOT, SGPT enzymes (greater than 500 IU/L) and, in a single instance, SGPT was greater than 2,000 IU/L. The overall rate of occurrences of elevated liver enzymes and elevations to three times the upper limit of normal, however, did not significantly differ from the rate of liver enzyme abnormalities in placebo-treated patients. All abnormalities were reversible after discontinuation of Axid.

Cardiovascular — In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

CNS — Rare cases of reversible mental confusion have been reported.

Endocrine — Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to Axid. Impotence and decreased libido were reported with equal frequency by patients who received Axid and by those given placebo. Rare reports of gynecomastia occurred.

Hematologic — Fatal thrombocytopenia was reported in a patient who was treated with Axid and another H_2-receptor antagonist. On previous occasions, this patient had experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental — Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity — As with other H_2-receptor antagonists, rare cases of anaphylaxis following administration of nizatidine have been reported. Because cross-sensitivity in this class of compounds has been observed, H_2-receptor antagonists should not be administered to individuals with a history of previous hypersensitivity to these agents. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other — Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine administration have been reported.

Overdosage: Overdoses of Axid have been reported rarely. The following is provided to serve as a guide should such an overdose be encountered.

Signs and Symptoms —There is little clinical experience with overdosage of Axid in humans. Test animals that received large doses of nizatidine have exhibited cholinergic-type effects, including lacrimation, salivation, emesis, miosis, and diarrhea. Single oral doses of 800 mg/kg in dogs and of 1,200 mg/kg in monkeys were not lethal. Intravenous median lethal doses in the rat and mouse were 301 mg/kg and 232 mg/kg respectively.

Treatment —To obtain up-to-date information about the treatment of overdose, a good resource is your certified regional Poison Control Center. Telephone numbers of certified poison control centers are listed in the *Physicians' Desk Reference (PDR).* In managing overdosage, consider the possibility of multiple drug overdoses, interaction among drugs, and unusual drug kinetics in your patient.

If overdosage occurs, use of activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance.

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Additional information available to the profession on request.

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Axid® (nizatidine, Lilly)

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AROUND-THE-STATE

Continued from page 17

elected to serve on the board of directors of Citizens Savings Bank of Newton. Long owns the Medicine Chest drug store in the Mountain View community. Citizens Savings Bank's board of directors is comprised of 15 members and includes business and civic leaders from the communities within the institution's service areas—Alexander, Catawba, Lincoln and Gaston counties. The bank has assets of $234 million and 11 branch offices in the Catawba Valley.

Kaiser Permanente of Raleigh has named **Tim Kurek** director of pharmacy services for the NC region.

John I. Mackowiak of Chapel Hill has recently been elected to the office of Secretary for one of the seven Academic Sections in the American Association of Colleges of Pharmacy. Mackowiak will serve as Secretary in the Academic Section of Pharmacy Administration for the 1989/90 term.

Awards, Honors, Citations

Margaret C. "Peggy" Yarborough, director of the Diabetes Care Center in Cary, has been granted the status of Fellow of the Academy of Pharmacy Practice and Management (APPM) by the American Pharmaceutical Association (APhA). Yarborough was one of five APhA members selected as a Fellow. In order to become a Fellow, a candidate must complete a minimum of 10 years of progressive and distinguished professional practice and unusually outstanding achievement in the pharmacy profession, be an active member of one of the APPM Sections, and be recognized beyond his or her local area for accomplishments in serving the public health and advancing the profession of pharmacy. Yarborough received both her B.S. and M.S. in pharmacy from UNC-CH. She was selected for her accomplishments during her many years as a community pharmacist and more recently for her work with diabetes.

Martha Lyon of Lexington Memorial Hospital in Lexington has been named the Syntex "Hospital Preceptor of the Year" and **Steve Wilson** of Guilford College Drug in Greensboro has been named the "Community Preceptor of the Year" by the UNC School of Pharmacy students in recognition of their important contribution to the educational experience of future pharmacists. Lyon received her award at the Annual Meeting of NCSHP in High Point February 3, 1989. Wilson will be presented his award at the NCPhA awards luncheon in Myrtle Beach May 20, 1989. Their names will be added to a permanent plaque on display at the UNC School of Pharmacy.

Births

Beth Keiger Helpingstine and husband, Chuck, announce the birth of their son, Chase Lowell Helpingstine. He was born March 17, 1989, and weighed 8 lbs., 11½ oz. Beth is a 1985 UNC School of Pharmacy graduate and practices pharmacy at Rite Aid in Durham.

Deaths

C.W. Bynum, 81, New Bern, died November 20, 1988. A 1926 graduate of the UNC School of Pharmacy, he established Bynum's Drug Store in 1938 and was a registered pharmacist until his retirement in 1986. He was a member of the Board of Education, Board of Public Health, and New Bern Chamber of Commerce.

Affiliate News

The **Columbus County Pharmaceutical Association** recently donated $500 to the Southeastern Community College (SCC) Foundation, Inc. to be used as a scholarship for an SCC student preparing for a career in pharmacy. There are presently ten SCC two-year graduates enrolled in the schools of pharmacy at Campbell University and the Medical University of South Carolina. Association president, Parks Thomas, vice president, John Watson, and Secretary/Treasurer, Caroline Cox, presented the check to Dr. Stephen C. Scott, president of SCC. The association presently has 45 active members from Columbus and surrounding counties who meet regularly to keep up with the changing issues facing pharmacy today.

Approximately 70 pharmacists and 30 dentists attended the joint meeting of the **Wake County Pharmaceutical Association** and the Raleigh/Wake County Dental Society on March 7, 1989. Tim Ives, Pharm. D., from the UNC School of Pharmacy, lead a very informative discussion of "Antibiotic Therapy For Pharmacists and Dentists." The Wake AHEC assisted in planning and organizing the event.

Chris W. Warner, Ph.D.
Associate Director, Clinical Development, Glaxo Inc.;
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*Wiggins, Steven N. "The Cost of Developing a New Drug." Pharmaceutical Manufacturers Association, Washington, D.C., June 1987.

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Motivating Professionals

This is the sixth in a series of articles for professionals who manage and managers who lead professionals and those who are both. Pharmacists operate with one license, but fill many different professional roles in hospitals, chain stores, individual stores, drug companies and universities. Along the way they need a broad variety of management skills. These articles take a broad perspective on management concepts we hope you will be comfortable applying.

The psychological contract discussed last month is one aspect of the task of motivating, but there are others too. Motivational systems have to be designed to meet the three conditions of *expectancy theory*, one of the many theories of motivation—1) the task has to be one that the employee thinks is doable, 2) employees must believe that, if successful at the task, they will be rewarded, and 3) the employee must believe that the reward associated with that task will be big enough to justify the extra effort. Obviously, you are better off if the employee thinks that performing the task is a normal part of their job for which they are normally rewarded, than something above and beyond the call of duty.

This theory is often presented as a mathematical formula:

Motivation = Probability of success × Probability of receipt of reward if successful × Probability that reward will be worth the effort.

No one has operationalized these three variables, so there is no magic formula for motivation. The reason for the multiplicative model is to emphasize the fact that since probabilities are numbers between 0 and 1, the motivation will be zero if any one of the three is ignored and very low if any or all are perceived as low. An example was observed by a colleague of mine who has been working with scientific professionals in the People's Republic of China. He reports that research managers often fail to motivate people because they insist on rewarding the whole group after the precepts of Chairman Mao. Consequently the average reward per employee is too small to be significant. Furthermore, those who have been the major contributors see those who did little or nothing get the same rewards. The process ends up with the best contributors angry and less motivated than before.

Jan Carlzon, the phenomenally successful president of SAS, the Scandinavian airline, emphasizes the importance of rewarding both the individual and the group carefully.

Curtis P. McLaughlin

Everyone needs to feel that their contributions are noticed. The work we do and the recognition we get for it contribute to our own self-esteem. Especially in a service-oriented business where employees' self-esteem and on-the-job morale have an enormous impact upon customer satisfaction, a word of well-deserved praise can go a long way.

Of course, praise generates energy, but only if it is justified. Receiving unmerited accolades an be an insult that reveals indifference on the part of the bestower. . . .

I believe an organization that rewards its employees with real job satisfaction and a genuine sense of self-worth is more honest to itself and its staff. A better reward for doing a good job is being awarded well-defined responsibility and trust. Helping talented people blossom and develop is one

Continued on page 24

CURTIS P. MCLAUGHLIN is a Professor of Business Administration in the School of Business and Professor of Health Policy and Administration in the School of Public Health at the University of North Carolina at Chapel Hill. McLaughlin received his masters and doctorate degrees in Business Administration from Harvard Business School. He has written numerous management articles for a variety of publications, including Harvard Business Review, and has consulted for domestic and international corporations. Some of his professional interests include the production of professional services in research, engineering, medicine, public health and education; management of not-for-profit organizations; and productivity improvement.

MOTIVATING PROFESSIONALS

Continued from page 23

of management's toughest challenges. Resorting to empty promotions as the way of showing appreciation is tantamount to a confession of failure.

Simply put, the richest reward of all is being proud of your work.[1]

When we are dealing with professionals we are not dealing with someone who has to have a nickel in the slot every time they are to do something. They come with predetermined ideas of what is normal behavior for normal rewards and how they should be treated as people and as professionals.

One problem is that they cannot all be treated the same. That might be fair, but it wouldn't be effective. People have different needs and different goals. The manager is left with "different strokes for different folks." It is a delicate balancing act between issues of equity and issues of motivation. One of my daughters, when she was about 18 said to me. "Daddy, you don't think I'm as smart as the others do you?" I was shocked. "No, why?" "Well, you never pushed me as hard as the other three kids." I then explained that I considered her smart and very empathetic, but my experience with her was that pushing her had negative consequences, whereas the others tended to respond positively. Her face brightened considerably, but I was wondering what else I might have done to her and the others in trying to meet each child's unique needs.

In each situation motivation has to take into consideration the task, the rewards, the person and the situation. Some people thrive on challenges. Others are scared by them. Some people thrive on excitement. Others want peace and tranquility. In some situations the decisions are life-threatening. In others we can easily change our minds and reverse our decisions if things don't work out.

One author suggests that you can differentiate today's professional workers into five groups—those who pursue career success, those who pursue technical mastery, those who pursue excitement, those who pursue security, and those who see a job as a means to other, non-work ends; and that it is very important to know who is which. Probably most of us have a little of each of the five in us, but one or two will dominate. Promising a bright future with the company will be highly effective with only a portion of the population. The person who has a focus outside work has to be shown how doing good work will enhance those ends. The knowledge-oriented professional reacts best to challenges, to chances to gain new competencies. The basic point here is that you have to know the people you are motivating well and that one motivational scheme does not fit all professionals.

There are some general principles, however, for motivating professionals. The first is to treat the employees as professionals. Understand and respect the values of their profession. Do not threaten those values unless you are prepared to pay a heavy price. Earlier articles outlined the basics of a professional orientation. For motivation we can think in terms of three dimensions of needs—need for affiliation, need for achievement, and need for power. With professionals we can safely assume that a lot of other needs—food, clothing, shelter, personal safety—are already being met due to income and class. Need for achievement is what employers value most. They want achievers. In highly successful managers this is associated with a desire for power, defined as "influencing the activities and thoughts of a number of individuals."[2] Need for affiliation relates to the desire to be included or not excluded from group activities and interpersonal relationships. Wanting to be liked leads to both positive and negative results in bosses. What seems to be the most successful motivator in professionals is the need for achievement, to "exhibit goal directed behavior where the goal is moderately difficult—that is, there is a reasonable chance of success—and the individual is provided with specific feedback about personal performance."[3] Research suggests that very high need for achivement is needed for individual work and moderately high levels for team efforts.

If those are the people we want to select and we are successful in selecting them, how do we motivate them? Obviously, we have to give them goals to work toward, set levels of goals that are achievable with the resources available, and finally give them feedback in information and rewards based on their actual performance. That is not significantly different from the approaches recommended for all employees. Key elements involve gaining their commitment to the organization and its goals by:

Keeping them informed—finances, markets, competitive forces

Keeping them involved—consult them early and often

Keeping them happy—share the successes, celebrate, reward

Making the job worth it—instill pride in the company—earn it

Continued on page 34

DICKINSON'S PHARMACY

PHARMACISTS ARE TOO CHEAP!

"Let's face it, we pharmacists are *cheap*!" confessed a New Yorker in the front row. The group was discussing whether independent pharmacy has a future, and how much it might cost to rescue it.

The accusation pleased me. I've never had a free prescription from a pharmacist, but I'm frequently asked by pharmacists for a free newsletter or other editorial product (if you keep reading, you'll find out how to get another one!).

There's an old saying to the effect that you don't value what comes free or cheap. Pharmacy association dues are a fraction of others (e.g., journalists pay $360-$565 to the National Press Club, pharmacists $110 to APhA).

This may mean peril to the profession. Since most of pharmacy's reading matter is free, it also may not be valued, and thus the profession may not be arming itself with the knowledge needed to defend the traditional values of the profession and its survival.

In short, if you don't shoot back in this war, you should expect to be killed, professionally speaking. ("It's not actually making me bleed right now, and maybe it won't, ever — so why buy bullets?")

Recent new developments suggest that pharmacists will not have a lot of time to buy ammunition and fight back, even if they want to.

The new Medicare drug benefit, for example, begins in 1992, and it is already being infiltrated by mail-order interests (despite statutory language that ambiguously seems to require counseling but which is being bureaucratically circumvented).

Like HMOs, other private carriers and self-insured employers, Medicare is afraid that the drug benefit will be too expensive. And there has been a backlash against Medicare's published drug coverage premiums, co-pays and other costs. Something will have to give.

Even those with the most deeply-held convictions against the inflexible, impersonal nature of mail-order drugs, are finding themselves forced to consider this mechanism on cost grounds alone.

Who is dissauding them?

Frankly, they hear a babble of opposing voices, each shouting pieces of a message that is too complex to be quickly grasped. Some of the individual pharmacists who write letters and get on the phone are self-defeatingly emotional.

James G. Dickinson

I recently tried to talk an HMO benefits controller out of mandatory mail-order for all oral contraceptives. She was both sympathetic to the principle of face-to-face pharmacy and skeptical of any possible patient hazards in the mail-order alternative.

Such arguments as secondary monitoring for lifestyle changes in the case of drugs with narrow therapeutic thresholds and the risks of polypharmacy were over her head. Her world is dollars and cents.

The behavior of some pharmacists tends to encourage this perception. They don't routinely counsel or keep their patient profiles current, and they get active in policy issues only when hit in the wallet.

Unfortunately, these pharmacists seem to the ones that HMO benefits administrators patronize exclusively, for their own needs.

Getting the other, largely unheard side of pharmacy's story across is fundamentally difficult, and made next to impossible by the bottom-line myopia of the health cost containment crisis.

That's what is so important about December's

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James G. Dickinson . . . Who is this mystery man? Mr. Dickinson's column, Dickinson's Pharmacy, has been running in our journal for the last two years. His column is syndicated and appears monthly in many state pharmaceutical journals across the country. Mr. Dickinson is also editor and publisher of Dickinson's FDA and Dickinson's PSAO industry newsletters. He has served as assistant executive director of the American Pharmaceutical Association and Washington bureau chief for Drug Topics. His home is in Morgantown, West Virginia.

DICKINSON'S PHARMACY

Continued from page 25

call by RxNet, the national PSAO, for a $50-per-pharmacy injection of operating funds.

RxNet is the one great hope that community, face-to-face pharmacy has to get a sophisticated, effective story across, in terms that go beyond the bottom line cost of the drug commodity.

Working on a shoe-string, always too slowly (it was afraid to ask for more than $25 start-up dues from its participating pharmacies!), RxNet now has established the first national electronic data processing "switch" for all pharmacy claims transactions.

The importance of this can't be overstated, in a market that is quickly being locked into arbitrary systems configurations by the onrush of the Medicare drug benefit.

Will those systems allow all pharmacies equal access to the future? Can Medicare and other plans be educated about the value of the care that community pharmacy can provide, and its cost-effectiveness?

Who will make that effort for pharmacy, if it's not RxNet and its network of state PSAOs (most of which, incidentally, are also starved for resources by dues that are generally way too low)?

Do I hear you muttering, "what have they done for me lately?" To find out, send me your name and address to receive a free copy of my latest *Dickinson's PSAO* newsletter (P.O. Box 848, Morgantown, WV 26507-0848).

But first, please rush $50 to RxNet at 205 Daingerfield Road, Alexandria, VA 22314.

This feature is presented on a grant from G.D. Searle & Co., in the interests of promoting the open discussion of professional issues in pharmacy. G.D. Searle & Co. accepts no responsibility for the views expressed herein as they are those of the author and not necessarily those of G.D. Searle & Co.

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HEALTH RESOURCES FOR OLDER WOMEN

Health Resources for Older Women is a new publication available from the National Institute on Aging (NIA), of the National Institutes of Health. It provides up-to-date information and resources on major health issues that affect older women today. These issues include normal changes that occur during the aging process (such as menopause), activities that promote health (nutrition and physical fitness, accident prevention, and the safe use of medicines), physical disorders that affect older women more frequently than other groups (osteoporosis, urinary incontinence, and arthritis), and related concerns (caregiving and financial planning).

Helping women make educated decisions about their own health care is the long-range goal of this publication. Toward this end, **Health Resources**, contains listings of organizations and publications offering health information and services to older women. But the information in this handbook is not for older women alone. Women of all ages can benefit from the discussions and resources, as well as other family members, health care providers, librarians, and others with an interest in women's health.

Keeping up with new advances in medicine and health is more important today than ever before. Scientists still have many questions about what is appropriate health and medical care for middle-aged and older women—for instance, involving the use of hormone replacement therapy for symptoms of menopause and preventing osteoporosis. But research goes on continuously and can in a short time result in important advances that have a direct bearing on the prevention and treatment strategies each woman chooses. So the secret to preserving good health, experts believe, lies in having access to appropriate medical care, in practicing good health habits throughout life, and in obtaining sound health information.

To obtain your free copy, write to the NIA Information Center/Women, 2209 Distribution Circle, Silver Spring, MD 20910; or call (301) 495-3455.

Multiple copies of the handbook can be purchased from the Government Printing Office for $1.75 each. Bulk orders of 100 or more will receive a 25 percent discount. Cash, checks, money orders, and Visa or Master Charge are all accepted (checks should be made out to Superintendent of Documents). Please indicate stock number 017-062-00141-3 on your order and send it to Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

CONTINUING EDUCATION PROGRAM ANNOUNCEMENT

The implications of the Institute of Medicine's (IOM) report on public health will be the focus of a statewide forum entitled THE FUTURE OF PUBLIC HEALTH. Programs will be presented May 11 in Asheville, May 18 in Winston-Salem, June 8 in Greenville and June 15 in Fayetteville.

The statewide forum is sponsored by the UNC School of Public Health, the NC Division of Public Health, the NC Public Health Association, the Association of NC Boards of Health, the NC Association of County Commissioners, the NC Association of Local Health Commissioners, the NC Area Health Education Centers.

Dr. Hugh H. Tilson, former NC state health director, will review the IOM report and its implications. Dr. Sarah Morrow, a former local health director and former secretary of the NC Department of Human Resources, will moderate a reactor panel including Dr. Ronald H. Levine, current state health director, and Dr. Michel A. Ibrahim, dean of the UNC School of Public Health. Participants will split up into small workgroups to discuss the implications of the IOM report recommendations for the state. Their recommendations on how to strengthen public health in North Carolina will be distributed to participants following the forum.

Each forum program begins at 3:00 p.m. and concludes at 8:30. Dinner is included in the $40 registration fee.

For further information or to register, contact Brenda Mauer, Registrar, Office of Continuing Education, UNC School of Public Health, CB #8165, Miller Hall, Chapel Hill, NC 27599-8165 (telephone: 919/966-4032).

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CORRESPONDENCE COURSE
Advising Consumers on OTC Pinworm Remedies

by J. Richard Wuest, R.Ph., Pharm.D.
Professor of Clinical Pharmacy
University of Cincinnati, Cincinnati, Ohio
and
Thomas A. Gossel, R.Ph., Ph.D.
Professor of Pharmacology and Toxicology
Ohio Northern University, Ada, Ohio

Goals

The goals of this lesson are to:

1. discuss means to prevent and treat pinworms; and
2. present important consumer information about pinworms and the treatment of pinworms.

Objectives

At the conclusion of this lesson, participants will be able to:

1. discuss the life cycle of pinworms;
2. describe means to prevent and treat pinworm infestations;
3. define the term anthelmintic as it relates to OTC drugs;
4. present the FDA/OTC advisory panel's conclusions on safe and effective anthelmintic drugs; and
5. comment on the future of OTC anthelmintic therapy.

It is enigmatic that pinworm infestation is considered to be self-diagnosable and self-treatable. Yet, there are no OTC products currently available that are both safe and effective for home use.

Gentian violet, long used for self-treatment of pinworms, is now considered by FDA to be potentially unsafe. Pryantel pamoate (Antiminth®), available for years as a proven, effective pinworm medication on prescription order, has been recommended for OTC status. Its manufacturer has not shifted it at the time of publication of this article.

This article discusses pinworm infestations. It identifies how the problem occurs and why all family members should be treated when any one member is affected. It describes hygienic measures important to eradicate and prevent spread of pinworms. It then discusses the status of OTC drug therapy useful in treating the condition.

Pinworm Infestation

Pinworms (*Enterobiasis*) are variously referred to as threadworms or seat worms. They are among the oldest identified and most prevalent human parasitic infestation. Pinworm eggs have been found in 10,000-year-old fecal remains.

The worm currently affects an estimated 200 million people world-wide. Approximately 40,000,000 victims reside in the United States and Canada. Animals are not part of the pinworm cycle; only humans are infested.

Pinworms are spindle-shaped parasites that spend all but the last few hours of their life within the human alimentary tract. These last hours are spent externally on the anus as they emerge to lay their eggs.

Male worms are 2 to 5 mm in length and rarely seen, probably because of their small size. Females measure 8 to 13 mm (about one-fourth to one-half inch) and are light yellowish-white in color. The term *pinworm* was coined to describe their long, thin, pointed tail that resembles a stickpin.

The worms develop from eggs that reach the gastrointestinal (G.I.) tract. Eggs are fully embryonated and become infective within a few hours after deposition within the G.I. tract. Worms hatch in the proximal small intestine then migrate downward. They may temporarily attach to the wall of the jejunum and upper ileum, but this is rare.

Pinworms copulate in the distal portion of

Continued on page 30

in the service of pharmacy

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CORRESPONDENCE COURSE

Continued from page 29

the small intestine. Females then move on the lower bowel. They attach by their heads to the lining of the cecum, appendix, and adjacent large intestine. In this way, they feed while their eggs develop. Although frequently found impacted in great numbers within the appendix they rarely cause appendicitis, or other intestinal pathology.

Once a female's eggs have matured, the worm detaches from the intestinal wall and exits through the anus. This normally occurs during the night while the human host is asleep and the muscles are most relaxed. The period between swallowing an egg and emergence of a worm through the anus is approximately one month.

Once they come in contact with air, female pinworms expel their 10,000 to 11,000 "sticky" eggs over the anal and pubic areas. The adult worms then die shortly thereafter. Scratching and rubbing areas by the human also helps expel eggs.

Liberated eggs are resistant to damage due to loss of moisture, and can generally survive 2 to 3 weeks at room temperature. Eggs are infrequently laid within the bowel. If this occurs they are usually immature and not viable.

As stated previously, pinworms only infest humans. They show little preference for males or females; Caucasians, Orientals, or Blacks; or individuals of high or low socioeconomic status. However, they predominately affect children who live in crowded quarters. Once a child becomes infested, the problem then generally becomes a family affair!

As a general rule, pinworm infestation usually occurs by ingesting eggs which reach the mouth on contaminated hands. Eggs may adhere to the fingers or under the fingernails following scratching or handling contaminated undergarments, bed clothes, or other personal items belonging to the infested person. They can also be transmitted by contact, or by touching others who are infested.

Eggs may also be found in food or drink. They are light enough to float in air, so they can be unknowingly inhaled.

Recontamination occasionally occurs from retroinfection. Eggs located in the perianal area may hatch to larvae and then enter the anus. They continue movement upward into the large intestine where they mature. Retroinfection is rare. When it occurs, it is mainly a problem affecting adults.

Self-Diagnosing Pinworm Infestation

Pinworm infestations *per se* are asymptomatic because the worm is a benign parasite. Symptoms occur only when worms exit the anus. The most commonly reported one is anal itching (*pruritus ani*) that may vary from a mild "tickling" sensation to intense pain. Itching occurs because of the female worm crawling around, and because of the presence of eggs on the skin. When itching becomes so severe that it interferes with sleep, the victim may complain of restlessness, irritability, and insomnia. The person may display changes in behavior, and be inattentive and generally uncooperative in school and job-related matters, as unrelentless itching continues.

Vaginal itching (*pruritus vulvae*) and/or discharge have occurred in women after the worms have migrated into the vagina. A strong relationship between enterobiasis and urinary tract infection in young girls has likewise been suggested. Ova have been detected in vaginal smears of girls with these infections.

One method of assessing pinworm infestation is to cover the end of a cotton-tipped applicator or tongue depressor with celephane (i.e., Scotch) tape leaving the sticky side outward. This is then placed against the perianal area to collect eggs that may be present. This collection method alone does not lend to self-diagnosis because pinworm eggs are too small to see with the unaided eye. But eggs can be confirmed under a microscope. Egg collection (if any!) can be done at home. The specimen must then be taken to a physician or laboratory for diagnosis.

Another method is to look for the adult worms exiting the anus. After the child is asleep for approximately one hour, the worms become active. A parent can visually inspect the anus using a flashlight. Female worms may be seen actively moving about depositing eggs on the infested child.

Treatment

The primary goal for therapy of pinworm infestation is to completely eradicate the parasite and its eggs from the entire household. Effective treatment involves instituting drug therapy, and making sure that everyone in the family strictly complies to a hygienic protocol which will minimize the chance that the parasite will be transmitted to others.

All members of the household must be treated in order to eliminate the pinworm infestation. This can be effectively accomplished with anthelmintics. Exceptions to this rule include infants under the age of two, children weighing less than 25 pounds, and pregnant women. The afore-

mentioned persons require medical supervision.

Anthelmintics are drugs that destroy or eliminate intestinal worms. Some drugs that are lethal to pinworms are equally devastating to other worms such as the large roundworm and hookworm. However, since these parasites cause much more serious symptoms and complicating pathology, their presence is considered to be neither self-diagnosable nor self-treatable. A physician should be consulted for either disorder. OTC anthelmintics are indicated *only* for pinworms.

Due to the FDA/OTC advisory panel review of the anthelmintic market, available products will change dramatically. For many years, gentian violet (as Jaynes' P.W. Tablets) was the only agent that could be reliably used at home to eliminate pinworms. But numerous questions have been recently raised about its safety!

The FDA/OTC advisory panel that reviewed anthelmintics concluded that gentian violet was effective. In spite of potential side effects of nausea, vomiting, abdominal pain and diarrhea, and the fact that there are unanswered questions about possible carcinogenic and teratogenic activities, the panel nevertheless considered gentian violet to be generally recognized as safe when properly used.

To offset the probability of gastrointestinal side effects, the panel recommended to FDA that OTC gentian violet products be available only as enteric-coated tablets. In this dosage form, panel members felt that by delaying drug release until it reached the small intestine, the occurrence and intensity of G.I. tract irritation would be reduced and patient compliance enhanced.

After carefully reviewing the panel's report, FDA disagreed with this recommendation. The agency stated that in its opinion, the health benefit was far outweighed by potentially serious risks.

When reporting this in 1980, FDA asked for public comments on its decision. By the end of the prescribed two years waiting period, no comments had been received. So FDA announced its intention to remove gentian violet from the OTC marketplace.

Since there is no overt consumer danger present, gentian violet-containing pinworm remedies can continue to be marketed until FDA publishes its Final Monograph in the Federal Register. The major reasons why FDA suggested gentian violet be removed from the market are listed in Table 1.

TABLE 1

Reasons Why FDA Suggested That Gentian Violet Be Removed From OTC Pinworm Remedies

- High incidence of GI adverse effects, especially in children
- Potential toxicity
- Scarcity of acute toxicity data
- Low patient compliance
- relatively low efficacy
- Availability of superior anthelmintic (pyrantel pamoate)

Pyrantel Pamoate. This drug represents an interesting situation in that it is a prescription-only drug that has been recommended for shift to OTC status. Its safety and effectiveness in animals led to its use as a prescription item in treating a variety of human worm infestations.

When the OTC advisory panel concluded its studies, it reported that as of 1980, more than 100 million people worldwide had taken pyrantel pamoate without serious complications. Pyrantel pamoate had been one of the drugs of choice (along with mebendazole—Vermox®) against pinworms for over a decade. Few toxic reactions have been reported since the drug was introduced into human medicine in 1972. Retrospectively, it is difficult to pinpoint pyrantel pamoate as the cause of reported ototoxicity, optic neuritis, mental confusion and hallucinations occasionally observed in patients taking it concurrently with other drugs.

Additionally, long-term studies in laboratory animals have failed to attribute any morphologic changes to the drug. There have been no effects on fertility, reproduction, organ development or lactation.

One potential problem singled out by the panel and reiterated by FDA is that there is documented evidence of a transient elevation of the hepatic enzyme serum glutamic oxalacetic transaminase (SGOT) in a small percentage of children taking the drug. In all instances, SGOT levels returned to normal after therapy was discontinued. There is no confirmed liver damage associated with the use of pyrantel pamoate. Adverse effects reported for pyrantel pamoate are listed in Table 2.

These effects are not considered to contribute to a significant safety question in most patients. FDA nevertheless will require a warning state-

Continued on page 32

CORRESPONDENCE COURSE

Continued from page 31

ment on the labeling of OTC pyrantel pamoate products advising against unsupervised use in patients with liver disease. Other statements are presented in Table 3.

A major reason for the high safety profile of pyrantel pamoate is that it is not appreciably absorbed. It is virtually insoluble in water. Approximately 85 percent of each dose is excreted unchanged in the feces. The remainder appears in the urine as intact or partially metabolized drug.

Action and Dosing. Pyrantel pamoate is a depolarizing neuromuscular blocking agent. It acts in a manner similar to succinylcholine. The drug causes intense nicotinic stimulation of neuromuscular junctions, and also inhibits the enzyme cholinesterase. In other words, worms initially contract, but continued drug action soon results in a spastic paralysis. The worms' contractile hold on the intestinal wall is lessened. It falls away and is expelled.

The usual single dose of pyrantel pamoate suspension is 5 mg/pound of body weight, not to exceed 1gm. The same dosage regimen applies to both children and adults. Pyrantel pamoate can be taken any time of day, with meals or on an empty stomach, and straight-up or with juice, milk or other beverage.

Other Potential OTC Anthelmintics?

Piperazine Citrate. The FDA/OTC advisory panel reviewed one other prescription anthelmintic, piperazine citrate, for possible shift to OTC status. After studying the data, the panel concluded (and FDA agreed) that while it is generally safe, piperazine citrate is potentially too toxic for unsupervised use.

While they do not occur in many patients taking it, the drug has potential for causing neurotoxic side effects. These include mental confusion, uncoordination, epileptic seizures and somnolence to the extent that the benefit-to-risk ratio is inappropriate for OTC availability. Therefore, piperazine citrate will continue to require a prescription for use.

The panel did not investigate other pinworm remedies. It did urge manufacturers to review clinical data on their products with an eye toward switching them from prescription-only to OTC status when appropriate. However, there is no indication that another anthelmintic will be marketed OTC in the near future.

TABLE 2

Adverse Effects Reported For Pyrantel Pamoate

Gastrointestinal (most common): Nausea, vomiting, abdominal cramping, diarrhea
Anorexia
Headache
Dizziness
Drowsiness
Restlessness
Irritability
Insomnia
Rash
Transient elevation in SGOT levels

TABLE 3

Warnings For Labeling of Pyrantel Pamoate When It Becomes OTC

- If upset stomach, diarrhea, nausea or vomiting occurs with the use of this product, consult a doctor.
- If you have liver disease, do not take this product unless directed by a doctor.
- If you are pregnant, do not take this product unless you have pinworms yourself and are directed to take it by your doctor.

TABLE 4

Consumer Information On Pinworms

- Wash hands and under fingernails carefully before eating or drinking; repeat after each use of the toilet.
- Keep fingernails short and well trimmed.
- Keep fingers away from the mouth and nose.
- Pay strict attention to complete personal hygiene and household cleanliness; clean bathroom fixtures and vacuum carpets daily.
- Carefully wash and fold (without shaking) all sleep clothing, undergarments, bed linens, towels and washcloths each day. Soak these in ammonia water (one cupful/5 gallons cold water) for one hour if they cannot be laundered each day.
- Children should shower or take standup baths daily, preferably in the morning, and thoroughly wash and rinse the anal and pubic areas.

Patient Advice and Summary

Consumers purchasing an OTC anthelmintic remedy should understand the importance of proper dosing and adherence to directions. They should be made familiar with how the infection is transmitted and how it is best avoided.

Pinworms can be suspected whenever there is persistent rectal itching that cannot otherwise be explained. Important information for consumers about pinworm control is presented in Table 4.

Correspondence Course Quiz

Pinworms

1. The medical term that specifically describes the type of worm infestation that is self-treatable with OTC anthelmintics is:
   a. ascaris.
   b. enterobiasis.
   c. necator.
   d. strongyloides.

2. The major method for introducting a pinworm egg into the mouth is from:
   a. dog feces.
   b. drinking water.
   c. improperly cooked pork.
   d. contaminated hands.

3. The approximate time that it takes for a mature pinworm to emerge from an ingested egg is:
   a. 10 days.
   b. 30 days.
   c. 60 days.
   d. 90 days.

4. The anthelmintic that has been found to be safe and effective for OTC use by an FDA/OTC advisory panel is:
   a. pyrivinium pamoate.
   b. thiabendazole.
   c. pyrantel pamoate.
   d. mebendazole.

5. The trade name for the agent described in question #4 is:
   a. Antiminth®.
   b. Povan®.
   c. Antepar®.
   d. Jaynes' P.W. Tablets.

6. FDA has recommended that labeling of the product described in question #4 contain a warning against unsupervised self-medication in persons with:
   a. liver disease.
   b. heart disease.
   c. asthma.
   d. kidney disease.

7. The product described in question #4 acts on parasitic worms by:
   a. interfering with respiration.
   b. paralyzing them.
   c. inhibiting metabolism.
   d. inducing convulsions.

8. Which of the following is a true statement?
   a. Male pinworms are visible, female pinworms are normally not visible.
   b. *Pruritus vulvae* is the most common symptom of pinworm infestation.
   c. Pinworms exit from the anus most commonly just before the affected person falls asleep.
   d. Pinworm eggs laid on the external skin can survive 2 to 3 weeks.

9. All of the following are true statements EXCEPT:
   a. Pinworms only infest humans.
   b. Pinworms infrequently lay eggs within the human bowel.
   c. Pinworm eggs are light enough to float in air.
   d. Pinworms are a common cause of appendicitis.

10. Piperazine citrate was turned down as an OTC anthelmintic because of its potential to cause:
    a. cardiotoxicity.
    b. hepatotoxicity.
    c. neurotoxicity.
    d. teratogenicity.

CE test form on page 34.

MOTIVATING PROFESSIONALS

Continued from page 24

Making the job worth it—have and exhibit faith in them

Making the job worth it—make people responsible for their results

Being a visible manager—exhibit authority and responsibility

Being a visible manager—lead by example, show your own commitment

Being a visible manager—above all be a competent manager.[4]

This list is only illustrative of the many ways of getting committed, motivated professional workers. It would take too much space to take them up one point at a time, but they all fit very well with the theories of motivation outlined above. They are a good place to start.

---

[1]Jan Carlzon, *Moments of Truth*, Cambridge, MA: Ballinger Publishing Co., 1987, pp. 115, 117-118.

[2]M.J. Stahl, *Managerial and Technical Motivation*, New York: Praeger, 1986, p. 6.

[3]M.J. Stahl, *op. cit.*, p. 5.

[4]Adapted from P. Martin and J. Nicholls, *Creating a Committed Workforce*, London: Institute of Personnel Management, 1987.

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Continued on page 36

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Continued from page 35

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WOMEN IN PHARMACY: ATTAINING A MAJORITY ROLE?

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See Schering Report X: A Profession in Transition on page 5. See also Women in Pharmacy article on page 7.

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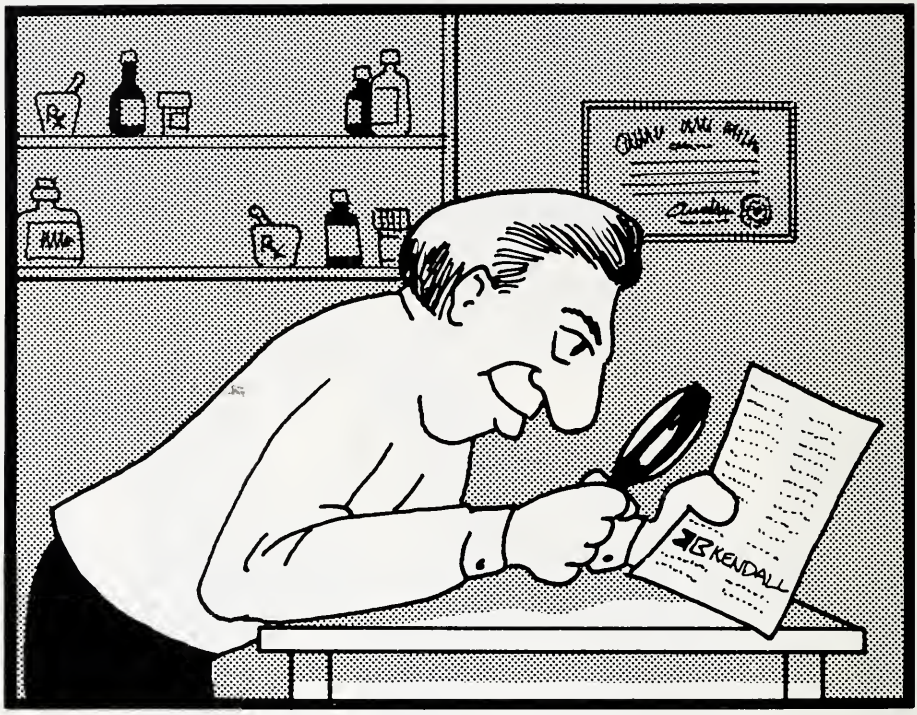

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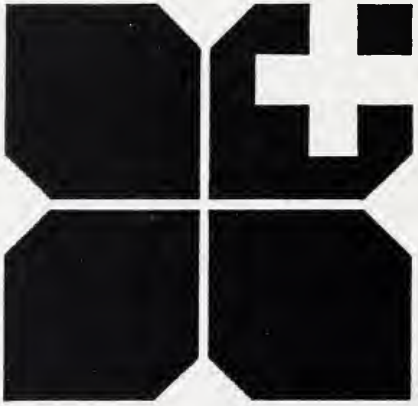

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SCHERING REPORT X
A PROFESSION IN TRANSITION

Schering Report X Reveals
Women Eventually Will Attain Majority Role in Pharmacy

A new, independent nationwide survey commissioned by Schering Laboratories reports that women are vaulting to a majority position in pharmacy and have already attained equal recognition and equal rewards in the profession.

"Twenty-eight percent of licensed pharmacists are women, and they account for about 60 percent of all students in colleges of pharmacy," said Dr. Jack Robbins, director-pharmacy affairs, Schering Laboratories at the 136th Annual Meeting of the American Pharmaceutical Association in Anaheim, CA, April 8-12, 1989. "Considering the growing presence of women in pharmacy, looking to the future, we are talking about at least a three-to-two ratio in favor of women, and the study suggests that this ratio may grow even larger."

Schering Report X, "A Profession in Transition: The Changing Face of Pharmacy," probes the nature and consequences of the ascendancy of women in pharmacy against a background where pharmacists are reexamining and reevaluating their choice of career, educational preparation and day-to-day working conditions.

In the 1988 study, nearly 400 pharmacists from every corner of the country—in small and large, rural and urban communities—were interviewed in depth. They included representatives from chain, independent and hospital pharmacies as well as health maintenance organizations (HMOs).

"In sifting for regional influences, the survey searched in vain," Robbins said. "While the day-to-day professional life of a pharmacist is pretty much the same in Altoona, Akron, or even Anaheim, differences did arise in important demographic characteristics such as sex and age."

The growing presence of women in pharmacy points to women pharmacists outnumbering their male counterparts in the future, the study indicated. "Given the relatively recent entrance of women in large numbers in pharmacy, it's no surprise that those already out of school and on the job tend to be younger," Robbins observed. "The average age of women pharmacists is 32, compared with 42 for men. To underscore the dynamics of their future impact on the profession, women pharmacists, while comprising 28 percent of all pharmacists, account for only 12 percent of pharmacists over age 40 but 57 percent of the under-30 segment."

Where are these mostly younger women pharmacists working? "Women represent 40 percent of pharmacy personnel in hospitals, 34 percent in chains and 19 percent in independents," he said. "As for being part of management, only 36 percent have advanced to owner/manager status."

"But a different picture emerges in narrowing the focus to pharmacists who entered the profession in the last five years," Robbins added. "Here, 25 percent of women pharmacists are in management ranks, the same proportion as men who also started working in the same period. Obviously, these women are not being denied their fair share of promotions."

There is no reason to believe, the study continued, that, as women pass through the seniority pipeline, they won't gain management status at the same rate as men. Women already have achieved respect as heads of retail and hospital pharmacies. Whether women will achieve statistical parity with men as owners of independent pharmacies will, in large part, be their own decision.

When women do become managers, the study went on, 75 percent have other pharmacists reporting to them, the exact same percentage as for men. How many reportees? 2.1 for male managers and 2.3 for women. Also, there was little if any difference in the size of the organizations women choose to work in. The numbers of total employees and of pharmacists were virtually identical.

"On careers and children," Robbins said, "three out of 10 women took time off from their careers to be mothers, with those over 40 more likely than their younger counterparts to have exercised the option. In most cases, the sabbatical lasted less than a year."

Just how well do women pharmacists fare in compensation? Looking at all men and all women who had started work in the last 10 years, women—at average annual earnings of $36,100—are paid the equivalent of 90 cents for every dollar earned by men, who have average annual salaries of $40,200.

The study pointed out, however, that these women pharmacists, presumably by their own choice, clock in a 9 percent shorter workweek than men—42 hours compared with 46 hours.

Continued on page 37

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WOMEN IN PHARMACY

On the preceding pages Schering Report X reveals that women will attain a majority position in pharmacy and have already attained equal recognition and equal rewards in the profession. The following women representing various practice groups in pharmacy were selected to appear in this month's feature from among our NCPhA members. These fourteen women were chosen for their professional achievements and contribution to the profession of pharmacy. Each was asked to respond to seven questions designed to glean their insights on various professional issues. Below is a brief biography introducing each woman and their responses to two of the following questions.

1. **In your opinion, what are the most important issues facing pharmacy today?**
2. **Schering Report X, a nationwide study commissioned by Schering Laboratories in 1988, revealed that women will attain a majority position in pharmacy. What impact do you think this will have on the profession?**
3. **Who in pharmacy do you most admire and why?**
4. **What are some of your professional goals and aspirations?**
5. **What is your favorite pharmacy publication and why?**
6. **How has your involvement in professional organizations benefitted you professionally?**
7. **What advice do you have for future pharmacists?**

KIM ADAMS

EDUCATION:

University of North Carolina at Chapel Hill, B.S. Pharmacy, 1989

EMPLOYMENT:

Revco Drug Stores, Asheville

INVOLVEMENT/HONORS:

President of Academy of Students of Pharmacy (ASP) 1987-1988

Vice President of Senior Class

UNC School of Pharmacy Drug Abuse Education Program, Coordinator

ASP Chapter Delegate for 1987 APhA Regional and 1988 National Meetings

Phi Lambda Sigma Pharmacy Leadership Society

American Thread Scholarship Recipient for four years

5. *American Druggist.* It provides the annual top 200 drugs, a synopsis of various drug classes, and other important articles on issues in pharmacy.

6. It has given me confidence in working with other health care professionals and in projecting my opinions. My work with the Drug Abuse Education program has given me insight to the importance of becoming involved with the community and the impact that can be made by the profession of pharmacy.

MARY LYNN McCRANIE BELL

EDUCATION:

University of North Carolina at Chapel Hill, B.S. Pharmacy, 1967

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WOMEN IN PHARMACY

Continued from page 7

EMPLOYMENT:

PharmaSTAT, Inc., Winston-Salem
Co-Owner, President, Board Director

INVOLVEMENT/HONORS:

North Carolina Pharmaceutical Association
American Pharmaceutical Association
UNC-CH School of Pharmacy Alumni Board

1. In order for pharmacy to continue to exist as we know it, the issues such as physician dispensing, mail order prescriptions, and HMO's must be addressed by a united pharmacy front. This is the time for all of us to speak out at least in support of the leaders we have to protect the interest of our profession.

2. I deal with male and female pharmacists daily. What I see are professionals judged on merit, not gender. In our pharmacist relief service business, you can rest assured, that the people we hire will be the best we interview. If pharmacy becomes a profession with a female majority, I believe it will be due to their academic and personal achievements, not that they are women. In my business or in the drug store that is filling my mother's prescriptions, I want the most qualified pharmacists. Professionally, the impact of women as a majority should not alter the practice of pharmacy.

LAURA GAITHER BURNHAM

EDUCATION:

University of North Carolina at Chapel Hill, B.S. Pharmacy, 1966

EMPLOYMENT:

PharmaSTAT, Inc., Winston-Salem
Co-Owner, Vice President, Secretary/Treasurer

University of North Carolina School of Pharmacy, Chapel Hill
Project Director, Hartford Foundation Grant: Management of Drug Therapy in Rest Homes
Research Assistant Professor, Division of Pharmacy Administration

INVOLVEMENT/HONORS:

North Carolina Pharmaceutical Association
Public Health Committee, chairman
Women in Pharmacy Committee, past chairman
various other committee appointments

American Pharmaceutical Association

North Carolina Society of Hospital Pharmacists

UNC School of Pharmacy Alumni Association, Board of Directors, past president

UNC School of Pharmacy Foundation of NC, Board of Directors

1. Government involvement and how we can maintain some control over our profession. Pharmacists tend not to be the most aggressive people, and it is a real fear that we may sit back and let various legislative bodies dictate rules, regulations and unsatisfactory fees without an effective lobby. I think it is essential that we not only support our organizations in their political activities, but that the various pharmacy groups work as a unit in the fight to maintain the integrity of our profession.

6. Greatly! It took a number of years of practice to recognize the need for active involvement in pharmacy organizations, but when I became active the assets became readily apparent. It gives one a view of their profession extending beyond the barriers of their individual practice; a chance to meet fellow pharmacists that one might never know; a chance to get involved and make a difference in the *future of your future.* The contacts made during various professional activities have been a tremendous asset in the development and growth of PharmaSTAT, with special recognition going to Al Mebane and the entire staff of NCPhA.

KATHLEEN M. D'ACHILLE

EDUCATION:

Wayne State University, B.S. Pharmacy, 1973
Wayne State University, Pharm. D., 1976
University of North Carolina at Greensboro, Masters of Education in Community Health, 1988

EMPLOYMENT:

SupeRx Drugs, Inc., Winston-Salem, Long Term Care Consultant Pharmacist

INVOLVEMENT/HONORS:

North Carolina Pharmaceutical Association
Public & Professional Relations Committee, past Vice Chairman, various other committee appointments
American Pharmaceutical Association
Working Group on Reimbursement for Cognitive Services, Chairman
Reference Committee on Professional Affairs, past Chairman
Clinical Practice Section of the Academy of Pharmacy Practice and Management, past Chairman
various other committee appointments
American Society of Hospital Pharmacists
Special Interest Group on Ambulatory Pharmacy Practice, advisory Working Group on Membership, past Coordinator
American Society of Consultant Pharmacists
ASCP-PAC, Board of Directors
North Carolina Society of Hospital Pharmacists, various committee appointments
Northwest Pharmacists Association
founding member, past President
Pharmacists Recovery Network
founding member and intervenor
Rho Chi National Honor Society

1. We, as a profession, need to put a great deal of energy into defining and describing pharmacy in a way that we can all agree upon. We then need to set goals for our profession. Until and unless we do this, we are vulnerable to attack from all fronts, and are unable to present a unified vision of the future of pharmacy to the world. Hopefully, the upcoming "Pharmacy in the 21st Century" conference will advance us in this direction.

7. My advice to future pharmacists: give yourself time to develop a love for the profession. Pharmacy is multifaceted, making the initial choice of a practice area sometimes difficult. By the same token, with the large number of opportunities available, there is something for almost everyone, and it's just a matter of exploring the options. Keep sight of your ideals, find your niche by trial and error if necessary, but don't give up, and you will find pharmacy to be extremely rewarding over time.

BETTY H. DENNIS

EDUCATION:

University of North Carolina at Chapel Hill, B.S. Pharmacy, 1972
University of North Carolina at Chapel Hill, M.S. Pharmacy Practice, 1977
University of North Carolina at Chapel Hill, Pharm. D., 1984

EMPLOYMENT:

University of North Carolina School of Pharmacy, Chapel Hill
Director of Continuing Education
Associate Director Pharmacy AHEC
Clinical Associate Professor, Division of Pharmacy Practice

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WOMEN IN PHARMACY

Continued from page 9

INVOLVEMENT/HONORS:

North Carolina Pharmaceutical Association
past Second Vice President
Constitution and Bylaws Committee, past Chairman
Continuing Education, past Chairman
various other committee appointments
North Carolina Society of Hospital Pharmacists
Program Committee, past Chairman
various other committee appointments
American Association of Colleges of Pharmacy
Membership Committee, past Chairman
American Cancer Society, N.C. Division
Family Health International
Protection of Human Subjects Committee, past Chairman
Rho Chi National Honor Society
UNC Order of the Valkyries
Lilly Achievement Award, 1972
Best Instructor, UNC School of Pharmacy, 1981, 1983-1985

6. Being involved in professional organizations has increased my awareness of issues facing the profession and it has given me opportunities to become involved in the growth of the profession.

7. Become actively involved in your profession and do not become too comfortable or satisfied with the status quo. Change will happen and we must position our profession to grow with these changes. Serve your community and promote the public health role of pharmacy.

LONI TRAYLOR GARCIA

EDUCATION:

University of North Carolina at Chapel Hill, B.S. Pharmacy, 1978
University of North Carolina at Chapel Hill, M.S. Pharmacy Practice, 1984

EMPLOYMENT:

North Carolina Memorial Hospital Pharmacy Department, Chapel Hill
Clinical Specialist, Ambulatory Care
University of North Carolina School of Pharmacy
Clinical Assistant Professor, Division of Pharmacy Practice

INVOLVEMENT/HONORS:

North Carolina Pharmaceutical Association
Convention Registrar, 1988, 1989
Past Third Vice President
Ethics Grievance and Practice Committee, past Chairman
Pharmacy Week Steering Committee, past Co-Chairman
Public and Professional Relations Committee, past Chairman
various other committee appointments
American Pharmaceutical Association
Academy of Pharmacy Practice and Management
American Society of Hospital Pharmacists
Ambulatory Care Special Interest Group
UNC School of Pharmacy Alumni Association Board of Directors
Rho Chi National Honor Society
NCPhA Certificate of Appreciation, 1985

4. To be an exemplary pharmacist for my colleagues and future pharmacists. I want to make an impact on improving health care by maintaining the focus of our profession—quality patient care.

5. I don't have a favorite. To keep abreast with state activities I read *The Carolina Journal of Pharmacy* and the *North Carolina Hospital Pharmacy Newsletter.* For nationwide and professional perspectives: *The American Journal of Hospital Pharmacy, American Pharmacy, Clinical Pharmacy, Drug Intelligence and Clinical Pharmacy,* and *U.S. Pharmacist.* No one publication satisfies my professional information needs.

SANDRA HARDEE HAK

EDUCATION:

University of North Carolina at Chapel Hill, B.S. Pharmacy, 1974
University of North Carolina at Chapel Hill, Pharm. D., 1984

EMPLOYMENT:

ProPharm, Ltd., Chapel Hill (an independent firm specializing in teaching, consulting, writing, editing, and managing and coordinating research), President
North Carolina Society of Hospital Pharmacists
Administrative Director
University of North Carolina School of Pharmacy
Clinical Assistant Professor, Division of Pharmacy Practice

INVOLVEMENT/HONORS:

North Carolina Pharmaceutical Association
Durham-Orange Pharmaceutical Association
North Carolina Society of Hospital Pharmacists
Board of Directors, ex-officio
various other committee appointments
American College Health Association
Ad Hoc Pharmacy Committee, past Chairman
Planned Parenthood of Orange County Medical Committee
UNC Order of the Valkyries Honor Society, past Vice President
Rho Chi national Honor Society, past Secretary
UNC Order of the Golden Fleece Honor Society
Upjohn Achievement Award, 1974
UNC School of Pharmacy Practice Award, 1974
UNC Algernon Sidney Sullivan Award, 1974

3. Peggy Yarborough. She had lots of courage to start the Diabetes Care Center in Cary in order to provide a much needed service for diabetic patients. She is smart and single-minded, recognized nationally, full of energy—amazing!

4. To promote pharmacy as a professional service to patients, so that the benefits of providing these services receive the economic recognition they deserve.

DIANA MARIE MARAVICH

EDUCATION:

Campbell University, B.S. Biology, 1986
Campbell University, Pharm.D. Candidate, 1990

INVOLVEMENT/HONORS:

North Carolina Pharmaceutical Association
Academy of Students in Pharmacy
Executive Student Council
Kappa Epsilon Fraternity, President
Interfraternity Council, past President
Zada M. Cooper Scholarship, 1988
Kappa Epsilon Alumni Award, 1988
Randall and Claude Abernathy Scholarship, 1988
Kappa Epsilon President's Award, 1988

1. One issue that is of a particular interest to me is the geriatric population and how to better serve them. I especially enjoy the direct contact with these patients. I believe that the pharmacist can provide such an abundance of information for these citizens. It seems that aiding this group is not

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WOMEN IN PHARMACY

Continued from page 11

only helpful to them but also rewarding for the pharmacist.

6. I believe my involvement with professional organizations has been an eye opening experience. You must learn quickly how to organize, delegate and be firm. At the same time, the most I have gained is friendship and mutual working relationships.

MARTHA GABRIEL PECK

EDUCATION:

University of North Carolina at Chapel Hill, B.S. Pharmacy, 1974

University of North Carolina at Chapel Hill, M.S. Pharmacy Practice, 1977

EMPLOYMENT:

Burroughs Wellcome Co., Research Triangle Park

The Burroughs Wellcome Fund, Executive Director

INVOLVEMENT/HONORS:

North Carolina Pharmaceutical Association

Wake County Pharmaceutical Association, past President

American Pharmaceutical Association

North Carolina Society of Hospital Pharmacists

Presidential Service Award, 1985

Southeastern Council of Foundations, Board of Trustees

Outstanding Young Women in America, 1983

Who's Who in American Colleges and Universities, 1974

Merck Award, 1974

Rho Chi National Honor Society

2. I have heard some critics lament the increasing number of women in pharmacy, citing the expected decrease in legislative efforts and alumni giving, and the loss of productivity due to childbearing. We must prove them wrong. A viable profession is an active profession and we must work to continually strengthen it.

3. I think there have been many individuals from the UNC-CH School of Pharmacy who influenced my career development: Dr. Tom Miya, Dean, Dr. George Hager, former Dean, Mr. Fred Eckel, Chairman, Division of Pharmacy Practice. All taught me the importance of doing a superlative job and not limiting myself in my career aspirations.

JAN HIRSCH PHILLIPS

EDUCATION:

University of South Carolina, B.S. Pharmacy, 1980

University of South Carolina, M.S. Pharmacy Administration, 1983

University of South Carolina, Ph.D.

EMPLOYMENT:

University of North Carolina School of Pharmacy, Chapel Hill

Assistant Professor, Division of Pharmacy Administration

INVOLVEMENT/HONORS:

North Carolina Pharmaceutical Association

American Pharmaceutical Association

American Association of Colleges of Pharmacy

American Society of Hospital Pharmacists

National Association of Retail Druggists—Faculty Liaison

Stephen H. Ashcraft Pharmacy Management Fellow
Rho Chi National Honor Society
Outstanding Young Women of America

4. I would like to be influential in preparing and stimulating pharmacy as a profession to become effectively pro-active in our changing professional environment.

7. Focus on the big picture: the role of the pharmacist's services in the health care system. Too often pharmacists see themselves merely as dispensers of a tangible drug product rather than an integral part of preserving and improving the health of our nation in a cost effective manner.

LORI TUTTEROW SETZER

EDUCATION:
University of North Carolina at Chapel Hill, B.S. Pharmacy, 1983

EMPLOYMENT:
Revco Drug Stores, Winston-Salem
Pharmacist-Manager

INVOLVEMENT/HONORS:
North Carolina Pharmaceutical Association
NC Pharmacy Week Steering Committee, past Co-Chairman
Public and Professional Relations Committee, past Co-Chairman
various other committee appointments
Northwest Pharmacists Association
Executive Committee, past President, past First Vice President, past Second Vice President, Program Committee, past Co-Chairman
American Pharmaceutical Association Delegate to National Convention, 1986, 1988, 1989
Practitioner Instructor, UNC School of Pharmacy
Northwest AHEC Advisory Committee
Revco Pharmacy Task Force (Region 4)

3. There are so many good role models from which to choose. As a chain pharmacist, I have to admire Al Lockamy and how he has balanced a career in pharmacy and his association activities. Another person I admire is Kathy D'Achille. She is a confident, successful practitioner and has the ability to get things done. Her activities on local, state and national levels have been an inspiration to me.

7. GET INVOLVED. The profession of pharmacy is what you make it to be. Involvement in professional organizations allows you to: 1) improve your practice by updating your knowledge and skills through C.E., 2) allows you to have a voice in your profession, 3) provides for interaction with fellow pharmacists.

CINDY DOLLAR-SMITH

EDUCATION:
University of North Carolina at Chapel Hill, B.S. Pharmacy, 1976

EMPLOYMENT:
Buncombe County Health Department, Asheville
Chief of Pharmacy

INVOLVEMENT/HONORS:
North Carolina Pharmaceutical Association
Western Carolina Pharmaceutical Association, past President
UNC School of Pharmacy Alumni Association, Board of Directors, past member
Buncombe County Health Department Staff Association, President
Western NC Public Health Association

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WOMEN IN PHARMACY

Continued from page 13

1. Physician dispensing and the number of people who need medications but cannot afford them.

4. I would like to see more pharmacists (including myself) get involved in community activities by talking to schools, etc., about drugs and pharmacy.

LAURA McLEOD VANCE

EDUCATION:

University of North Carolina at Chapel Hill, B.S. Biology, 1979
University of North Carolina at Chapel Hill, B.S. Pharmacy, 1981
Appalachian State University, Certificate in Health Care Management, 1988

EMPLOYMENT:

Winston-Salem Health Care Pharmacy, Winston-Salem

INVOLVEMENT/HONORS:

North Carolina Pharmaceutical Association
Executive Committee, Member-At-Large
various other committee appointments
Northwest Pharmacists Association
founding member, past President, past Vice President
Public and Professional Affairs Committee, Chairman
American Pharmaceutical Association
Delegate to National Convention, 1985, 1986, 1988
UNC School of Pharmacy Alumni Association
Board of Directors, past member
Kappa Epsilon Alumni Association
past President
National Finance Committee
Phi Lambda Sigma, 1981
Marion Laboratories Distinguished Young N.C. Pharmacist of the Year, 1988

3. There are two people whom I admire and try to model myself after—each for different reasons. The first is Marilee Rudy, treasurer for APhA. Marilee is not only active in various professional associations, she is the owner of two pharmacies and mother to two sets of twins. She is an excellent example of what can be done with dedication to the profession, time management and a supportive spouse. The second person I most admire is my uncle, Don Bennett, who has practiced for 30 years. He has always been cheerfully available to his patients. It is rare for him not to be called at home by a patient with a problem or medication question. He knows his patients well and truly cares about them and their needs. His type of pharmacy practice is unfortunately not a typical one today, but one to which we can all aspire.

5. I try to read a variety of professional publications each month. One of my current favorites is *Pharmacy Times*. It contains interesting C.E. articles that I can apply in my practice, trade information, and what's happening in pharmacy at the national level. I depend on *The Carolina Journal of Pharmacy* and the *NCPhA Tar Heel Digest* to keep me informed at the state level and in keeping up with my colleagues.

MARGARET "PEGGY" YARBOROUGH

EDUCATION:

University of North Carolina at Chapel Hill, B.S. Pharmacy, 1966

University of North Carolina at Chapel Hill, M.S. Pharmacy Practice, 1978

EMPLOYMENT:

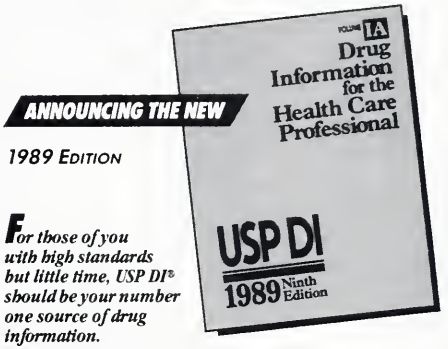
The Diabetes Care Center, Cary
Owner and Director
Health Center Pharmacy, Cary
Co-Owner
Pharmacy Consultation Services, Cary (private firm specializing in patient and family education in the areas of diabetes and chronic disease or conditions), Co-Owner, Director and Clinical Pharmacist

INVOLVEMENT/HONORS:

North Carolina Pharmaceutical Association
Wake County Pharmaceutical Association
American Pharmaceutical Association
Specialty Council on Nuclear Pharmacy
Cognitive Services Working Group
Board of Pharmaceutical Specialties
North Carolina Society of Hospital Pharmacists
past treasurer American Society of Hospital Pharmacists
American Diabetes Association
various committee appointments and offices
NC Affiliate, American Diabetes Association
various offices
Editorial Board, *Diabetes Spectrum*
Rho Chi National Honor Society
Certified Diabetes Educator
NCPHA Bowl of Hygeia Award, 1986
APhA Daniel B. Smith Award, 1988
Fellow of the Academy of Pharmacy Practice of the APhA, 1989
Various other awards, honors, and professional affiliations

2. When pharmacy is practiced by a variety of different individuals—men, women, different cultures, different races, etc.—the scope of our profession cannot help but expand and better meet the needs of the variety of patients we serve. I think this is already evident as the number of women pharmacists has increased. However, more women pharmacists is not necessarily the same thing as more women pharmacy leaders. I think it will be a very positive impact on our profession when pharmacy leaders more closely reflect the mix of pharmacy practitioners.

4. To promote and further the role of pharmacy and pharmacists as indispensable health care providers. We cannot rely upon legislation to accomplish this for us—rather, it must be accomplished by the actions of individual pharmacists, and by pharmacy as a profession, demonstrating value in the arenas of drug information, patient education, patient advocacy, non-prescription monitoring, health screening, community involvement, and provision of drug dispensing services. My overall goal is to add in some way to this direction for pharmacy.



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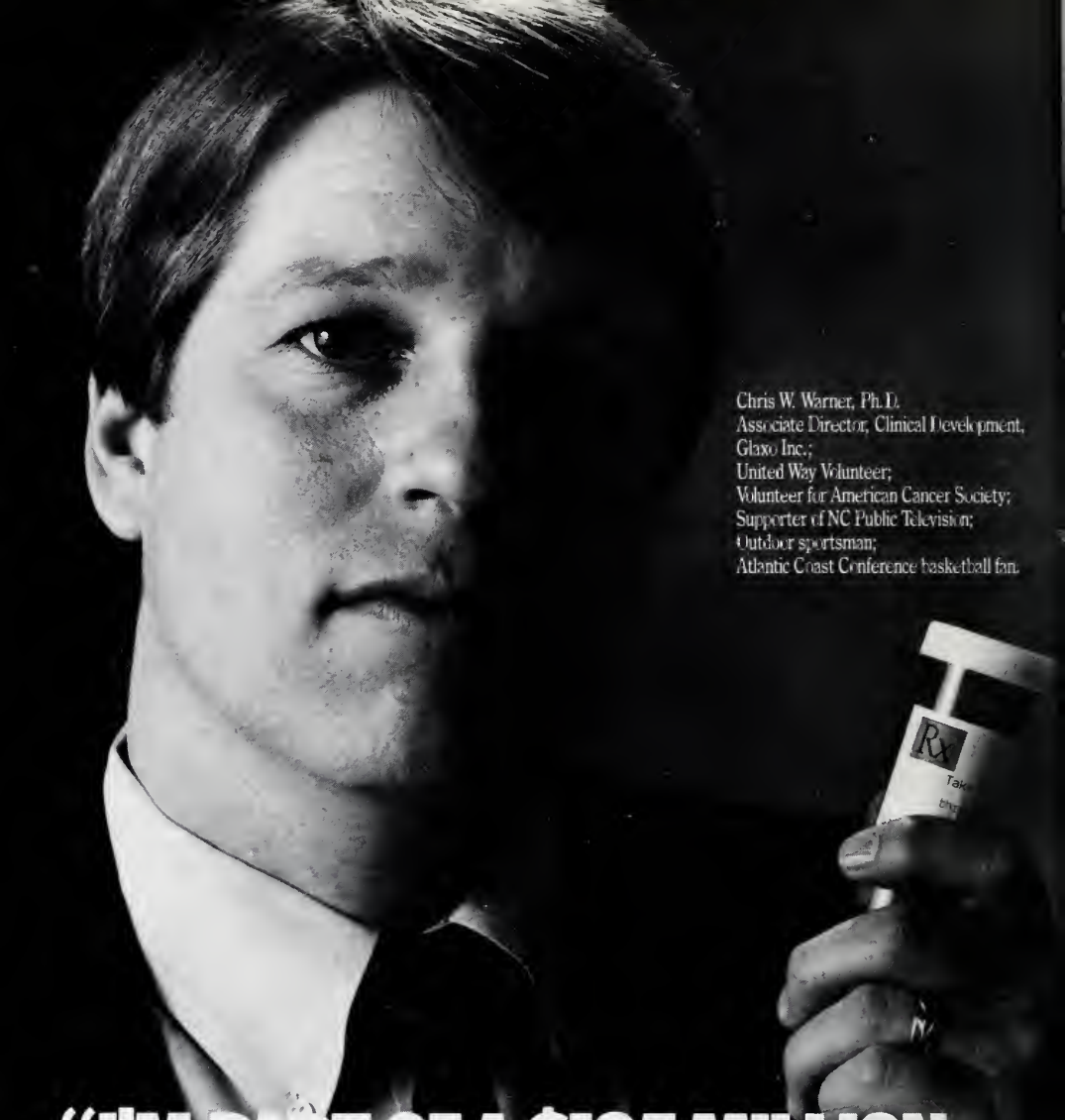

Chris W. Warner, Ph.D.
Associate Director, Clinical Development, Glaxo Inc.;
United Way Volunteer;
Volunteer for American Cancer Society;
Supporter of NC Public Television;
Outdoor sportsman;
Atlantic Coast Conference basketball fan.

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*Wiggins, Steven N. "The Cost of Developing a New Drug." Pharmaceutical Manufacturers Association, Washington, D.C., June 1987.

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Glaxo Inc., Research Triangle Park, NC 27709

FONNIE JACKSON ANDREWS AWARD RECIPIENTS 1989

The following essays were written by the 1989 recipients of the Fonnie Jackson Andrews Award, Eugene G. Brown of Dublin and Katurah A. Hartley of Rocky Mount. The award recognizes students who demonstrate a "positive attitude of finding what is right with pharmacy and not what is wrong" (Mr. Andrews' own words). To be eligible for the award students must meet the following criteria:

- 3/5 or 4/5 students who display a positive image by their activities in the School of Pharmacy, pharmacy organizations inside or outside the School, the practice of pharmacy, or by public service associated with health care.
- nomination by a fellow student or faculty member
- demonstrate excellent written communication skills via a short essay describing their dedication to pharmacy
- demonstrate excellent oral communication via interviews by the pharmacy faculty.

Mr. Andrews (1892-1983) was a 1915 graduate of the UNC School of Pharmacy and a devoted friend and benefactor of the School of Pharmacy, the Kappa Psi Fraternity, and the Pharmacy Foundation of North Carolina. Through his gift to the School of Pharmacy an award bearing his name was established in 1975 to recognize those students of pharmacy who make outstanding contributions to the profession of pharmacy. The award is accompanied by a minimum scholarship of $1000.

This year two 1989 award winners were honored at an annual awards ceremony and banquet held by the UNC School of Pharmacy at the Omni Europa Hotel in Chapel Hill on April 27, 1989.

What I Can Do As An Individual Practitioner To Advance The Profession of Pharmacy

Eugene G. Brown
Co-recipient of the 1989 Fonnie Jackson Andrews Award

The profession of pharmacy is amidst a very important and exciting time. The ability of pharmacists to adjust to change while maintaining high professional, moral and ethical standards will serve to strengthen pharmacy and to ensure the continued success of the profession.

Pharmacy has always been a very important part of my life. Working in my father's drug store while growing up, I was fortunate to learn the importance of pharmacy to the community at a young age. I grew to love the personal contact, and the feeling of gratification after helping people in need was very rewarding. I came to college with aspirations of myself also becoming a retail pharmacist, but at the same time I wanted to explore as many parts of pharmacy as possible.

The expansion of retail pharmacy, the advent of clinical pharmacy and the differentiation of the role of pharmacists in many different health care related fields has created many opportunities for today's pharmacist. Summers at two different independent pharmacies, and working with both third party adminstration and pharmaceutical industry has provided me with a wide variety of pharmacy experiences. This summer I plan to work in chain pharmacy management to broaden my pharmacy background even more.

The cutting edge of retail pharmacy centers around individualization of services and expansion into home health care. With increasing commercialization and competition, pharmacists must make every effort to preserve professionalism. When time and speed are factors, personnel adjustments must be made to allow the pharmacist adequate time with each patient. Increased efforts to counsel, to give over-the-counter recommendations and to encourage patients to ask drug and disease related questions will elevate the patient/practitioner relationship to a level that allows for maximization of health care delivery.

Pharmacists must become motivators and take an active role in preventative health care. Screening clinics and other health promotive/disease preventative steps (such as nutritional awareness, cholesterol and high blood pressure monitoring) will become commonplace and serve to address this need. Pharmacy has developed into the nation's most well-respected profession. Pharmacist's efforts have made this possible, and as the future of pharmacy we must work even harder to maintain this status.

Home health care will prove to be a most exciting field. With the growing numbers of geri-

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ANDREWS AWARD

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atrics, the incorporation of diagnostic related groups and with Catastrophic Health Care provisions, the pharmacist must vacate his classical "behind the counter" approach and offer services in the homes of their patients.

The advent of clinical pharmacy has been one of the biggest movements in pharmacy within recent years. The concept of the "team approach" to health care with increased communication and cooperation between practitioners and with clinical pharmacists actually rounding with medical doctors, the effectiveness of the pharmacist as a health care provider has been demonstrated. Professionalism within this practice has set a precedent for maximization of health care, and this area will evolve into a standard for twenty-first century health care.

To keep up with increasing technology and information, additional educational training for pharmacists is necessary. Active participation in continuing education and provisions for an all Pharm.D. curriculum will enable both retail and clinical pharmacists to meet patient needs more adequately.

Participation of pharmacists and pharmacy students in pharmaceutical and community associations will become increasingly important in allowing pharmacy to adapt to changing demands in health care. Communication and leadership skills developed in these efforts will enable pharmacists to be more effective in the delivery of medical assistance to those in need.

I feel that pharmacy is in the middle of a very interesting period of change and opportunity. The ability of the pharmacist to adapt to change and to meet the individual needs of patients will be both challenging and rewarding. Utilization of leadership skills obtained in pharmacy organizations will enable pharmacists to become leaders in health care. Pharmacy has always been important to me, and in this profession I seek to serve as both provider and educator in advancing the profession of pharmacy.

What I Can Do As An Individual Practitioner To Advance The Profession of Pharmacy

Katurah A. Hartley

Co-recipient of the 1989 Fonnie Jackson Andrews Award

At this point in my pharmacy education I have many decisions to make. Do I want to work in community or hospital pharmacy? Should I get an advanced degree? Although many aspects of my future are unclear, one is certain. In my heart, I am dedicated to pharmacy; a commitment to a wonderful profession which I began when I was sixteen. Pharmacy already has done so much for my personal enrichment, that I feel I owe it my best. To advance pharmacy as an individual practitioner, will require dedication, active participation, and above all the highest ethical standards.

As in pharmacy school, I plan to be an active participant in the profession as well as my community. Having multitudes of activities is my life stimulant. I honestly enjoy providing service and leadership for the benefit of others. Therefore I want to be an active member in the pharmacy associations. It's these organizations that keep pharmacy united. The pharmacy associations are also a great place to initiate change, foster professionalism, and discuss pharmacy's future. To me, active, unselfish commitment to such organizations communicates sincere concern for the profession to fellow practitioners.

I also intend to serve my community, not only as a pharmacist but as a citizen. Communities thrive on the fellowship and hard work of its members. Becoming a concerned, active participant can only help strengthen the community as well as the reputation of pharmacy.

Above all, it's the reputation of pharmacy I intend to preserve. I shall conduct business with the highest ethical standards, realizing it's my duty to protect and enhance the health and welfare of my patients. Providing quality, professional care can only impart high esteem for the profession. Acquiring such a reputation amongst citizens will help foster the demand, and thus the preservation of pharmacy.

In essence, I will have to give the best of Katurah Hartley in order to advance pharmacy. It is a rewarding, challenging career I seek. May I meet my needs and simultaneously enhance the needs of the others through the profession of pharmacy.

AROUND THE STATE

In response to the recent Readers' Survey conducted by The Carolina Journal of Pharmacy, this column, featuring news around the state, has been resurrected from the past. The NCPhA staff welcomes your comments and any contributions you wish to make to this column. Photos are also welcome. Send us your news!

Awards, Honors, Citations

William T. "Bill" Sawyer was one of six pharmacists nationwide designated a Fellow of the American Society of Hospital Pharmacists. "Fellow" designation is intended to honor excellence in pharmacy practice and encourage public recognition and awareness of pharmacists who have distinguished themselves in pharmacy practice. Sawyer will be recognized during the Opening Session of the Annual Meeting of the American Society of Hospital Pharmacists in Nashville, June 4-8, 1989.

Al Mebane III was inducted into the national pharmacy leadership society, Phi Lambda Sigma, on March 21, 1989. The society selects only those individuals who have shown exceptional leadership ability in the advancement of the profession of pharmacy.

Michael Cooper of Lincolnton has been nominated for the Revco Volunteerism Award and the 1989 President's Volunteer Action award. Both citations recognize Cooper's efforts to raise community awareness about the dangers of drug abuse or misuse in the Lincolnton community in 1988.

Appointments

John I. Mackowiak of Chapel Hill and **Kathleen M. D'Achille** of Easley, SC (formerly of Clemmons, NC) were appointed by Speaker of the APhA House of Delegates, Lucinda L. Maine, to serve on 1989 APhA reference committees. Mackowiak was appointed to the Reference Committee on Professional Affairs and D'Achille was appointed to the Reference Committee on Public Affairs. The reference committees held public hearings during the APhA Annual Meeting in Anaheim, CA, April 8-12, 1989, to consider recommendations of the APhA policy committees.

During the APhA Annual Meeting in Anaheim, CA, **Al Mebane, III**, Executive Director of NCPhA, was elected 2nd Vice President for the National Council of State Pharmaceutical Association Executives (NCSPAE). In addition, the newly installed NCSPASE president, Dan Leone, CT, appointed Mebane to the NCSPAE Program Committee.

Clyde Naylor of Greenville was recently installed as the 50th president of the Greenville Jaycees. He has been a member of the Greenville Jaycees since 1983. Naylor is a 1982 graduate of UNC-CH. He is currently employed at Pitt County Memorial Hospital and is president of Apple Nursing Services, Inc.

In The News

Customers, employees, friends and family celebrated **Gordon Bane's** 25th anniversary at Lowell Discount Drug Co. in Lowell, N.C. on May 4, 1989. Bane, a Hendersonville native, bought the now 69-year-old drug store in 1964. Dark wood shelves are decorated with reminders of Bane's 25 years at the store—old signs, antique bottles, and a framed needlepoint inscription: "Old Pharmacists Never Die They Just Get Refilled."

J. Frank Burton, Jr., president-elect of NCPhA, was among pharmacy association leaders from 47 states and Puerto Rico who attended a Leadership Training Conference in Kansas City, Mo. The two-day conference, sponsored by Marion Laboratories, Inc., was designed to provide incoming presidents of state pharmacy associations with practical information and instruction in leadership and management techniques to help make their term of office for the coming year a personally satisfying and productive experience. Burton is the owner of Burton's Pharmacy, Inc. in Greensboro.

In April, **Mickey Watts** of Concord led the annual education and funds crusade kickoff of the Cabarrus County Unit of the American Cancer Society. Watts is president of the local unit of the American Cancer Society.

The **Pharmaceutical Institute**, founded two years ago by an organization called Triangle East,

Continued on page 22

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Brief Summary
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Indications and Usage: Axid is indicated for up to eight weeks for the treatment of active duodenal ulcer. In most patients, the ulcer will heal within four weeks.

Axid is indicated for maintenance therapy for duodenal ulcer patients at a reduced dosage of 150 mg h.s. after healing of an active duodenal ulcer. The consequences of continuous therapy with Axid for longer than one year are not known.

Contraindication: Axid is contraindicated in patients with known hypersensitivity to the drug and should be used with caution in patients with hypersensitivity to other H_2-receptor antagonists.

Precautions: *General* — 1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy

2. Because nizatidine is excreted primarily by the kidney, dosage should be reduced in patients with moderate to severe renal insufficiency.

3. Pharmacokinetic studies in patients with hepatorenal syndrome have not been done. Part of the dose of nizatidine is metabolized in the liver. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests — False-positive tests for urobilinogen with Multistix® may occur during therapy with nizatidine.

Drug Interactions — No interactions have been observed between Axid and theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450-linked drug-metabolizing enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increases in serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility — A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice; although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a two-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy — Teratogenic Effects — Pregnancy Category C — Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus and at 50 mg/kg it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers — Studies conducted in lactating women have shown that <0.1% of the administered oral dose of nizatidine is secreted in human milk in proportion to plasma concentrations. Caution should be exercised when administering nizatidine to a nursing mother.

Pediatric Use — Safety and effectiveness in children have not been established.

Use in Elderly Patients — Ulcer healing rates in elderly patients are similar to those in younger age groups. The incidence rates of adverse events and laboratory test abnormalities are also similar to those seen in other age groups. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of nizatidine included almost 5,000 patients given nizatidine in studies of varying durations. Domestic placebo-controlled trials included over 1,900 patients given nizatidine and over 1,300 given placebo. Among reported adverse events in the domestic placebo-controlled trials, sweating (1% vs 0.2%), urticaria (0.5% vs < 0.01%), and somnolence (2.4% vs 1.3%) were significantly more common in the nizatidine group. A variety of less common events was also reported; it was not possible to determine whether these were caused by nizatidine.

Hepatic — Hepatocellular injury, evidenced by elevated liver enzyme tests (SGOT [AST], SGPT [ALT], or alkaline phosphatase), occurred in some patients and was possibly or probably related to nizatidine. In some cases, there was marked elevation of SGOT, SGPT enzymes (greater than 500 IU/L) and, in a single instance, SGPT was greater than 2,000 IU/L. The overall rate of occurrences of elevated liver enzymes and elevations to three times the upper limit of normal, however, did not significantly differ from the rate of liver enzyme abnormalities in placebo-treated patients. All abnormalities were reversible after discontinuation of Axid.

Cardiovascular — In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

CNS — Rare cases of reversible mental confusion have been reported.

Endocrine — Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to Axid. Impotence and decreased libido were reported with equal frequency by patients who received Axid and by those given placebo. Rare reports of gynecomastia occurred.

Hematologic — Fatal thrombocytopenia was reported in a patient who was treated with Axid and another H_2-receptor antagonist. On previous occasions, this patient had experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental — Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity — As with other H_2-receptor antagonists, rare cases of anaphylaxis following administration of nizatidine have been reported. Because cross-sensitivity in this class of compounds has been observed, H_2-receptor antagonists should not be administered to individuals with a history of previous hypersensitivity to these agents. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other — Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine administration have been reported.

Overdosage: Overdoses of Axid have been reported rarely. The following is provided to serve as a guide should such an overdose be encountered.

Signs and Symptoms — There is little clinical experience with overdosage of Axid in humans. Test animals that received large doses of nizatidine have exhibited cholinergic-type effects, including lacrimation, salivation, emesis, miosis, and diarrhea. Single oral doses of 800 mg/kg in dogs and of 1,200 mg/kg in monkeys were not lethal. Intravenous median lethal doses in the rat and mouse were 301 mg/kg and 232 mg/kg respectively.

Treatment — To obtain up-to-date information about the treatment of overdose, a good resource is your certified regional Poison Control Center. Telephone numbers of certified poison control centers are listed in the *Physicians' Desk Reference (PDR)*. In managing overdosage, consider the possibility of multiple drug overdoses, interaction among drugs, and unusual drug kinetics in your patient.

If overdosage occurs, use of activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance.

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Additional information available to the profession on request.

Axid® (nizatidine, Lilly)

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AROUND-THE-STATE

Continued from page 19

will graduate its first class in August 1989. Technical colleges in Wilson, Nash and Wake counties are all participants in the institute offering associate degrees in industrial pharmaceutical technology. Only a handful of colleges nationwide have such a program. Developed under the guidance of Glaxo, Inc., the program will prepare graduates for positions in manufacturing plants as research and development technicians, quality control technicians, instrumentation and control workers and in biological and chemical laboratories. Triangle East is an organization designed to promote economic growth within the triangle area between Wilson, Rocky Mount and Raleigh.

Pharmacist and artist, **Joe Miller** of Boone, has been commissioned by NARD, Washington, D.C., to paint a series of pharmacy scenes. The scenes will be printed in a limited edition and made available to pharmacists throughout the country. Proceeds from the print sales will go toward the restoration of America's oldest drug store, the Stabler-Leadbeater Apothecary Shop in Alexandria, VA, which opened in 1792 and closed in 1933. Miller is a partner in a small drug store chain in Boone and a past president of NCPhA. He has won many awards, including awards from the NC Watercolor Society. Gallery space in the Boone Drug Company building is provided for his paintings and other local and regional artists.

Weddings

Jane Amber Younts and David Phillip Stewart were married on April 22, 1989 in the First Baptist Church of Madison. The bride is a 1986 graduate of UNC-CH School of Pharmacy and is a pharmacist at Morehead Hospital in Eden. The couple is residing in Stoneville.

Births

Bruce E. and **Toni Teal Dickerson** of Elizabethtown announce the birth of a daughter, Jennifer Lauren, weighing 6 lbs., 7½ oz., on April 22, 1989, at Columbus County Hospital in Whiteville.

Deaths

Arthur G. Kiser died at his home in Asheville, February 19, 1989. He was 78 years old. Kiser was a former co-owner of Mintford Pharmacy and served as a pharmacist in Highland Hospital. He was an elder, deacon and treasurer of Malvern Hills Presbyterian Church.

AFFILIATE NEWS

New officers for the **Alamance County Pharmaceutical Society** were installed for the 1989-1990 year at the April 26 meeting. They are: president, Myra Mullis of Haw River; vice president, Gene S. Sherard of Burlington; and secretary/treasurer, Jack G. Watts of Burlington.—*submitted by Jack G. Watts, Secretary/Treasurer*

New officers for the **Cleveland County Pharmaceutical Association** are: president, Paul L. Covey of Shelby; vice president, Charles D. Blanton; secretary/treasurer, Mary Crawford. The officers' terms are effective through May 1990.—*submitted by Paul L. Covey, President*

The **Guilford County Society of Pharmacists** met on April 9 and May 14, 1989, at Moses H. Cone Memorial Hospital in Greensboro. Benny Ridout, R.Ph., Pharmacist Consultant, N.C. Division of Medical Assistance, spoke to the group about new H.C.F.A. rulings concerning state Medicaid programs at the April meeting. The topic for the May meeting was "Marketing Good Health: Prevention and Home Diagnostic Products." Charles C. Pulliam, Associate Professor of Pharmacy Practice, UNC-CH School of Pharmacy and Associate Director of the Center for Health Promotion and Disease Prevention made the presentation.—*submitted by Frank Burton, Jr., Secretary/Treasurer*

Approximately 150 pharmacists and manufacturer's representatives attended the **Wake County Pharmaceutical Association's** April 18 meeting at the Glaxo facility in Research Triangle Park. George Dukes, Jr. of the UNC School of Pharmacy gave a very informative talk on "The Importance of Maintenance and Management of Duodenal Ulcer Disease."—*submitted by Benny Ridout, President*

The **President's Remarks** does not appear in this month's journal as both our outgoing and incoming presidents were busily preparing for NCPhA's Annual Convention when this journal went to press. Ralph Ashworth, the new 109th president of NCPhA, will resume the President's Remarks next month.

Mortar and Pestle Award Dinner

Sponsored by
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1989 Pharmacist-of-the-Year

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Friday Night July 21, 1989
Reception – 7:00 to 8:00 p.m.
Dinner and Program – 8:00 p.m.

Dinner reservations at $ 23.50 per person
may be ordered through NCPhA

Overnight accomodations may be secured at the
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Third-generation pharmacist John Albert McNeill Sr. (left) of Whiteville was recognized for his service to the community at the Southeastern Community College (SCC) Foundation's Thirteenth Annual Dinner Theatre. On behalf of Governor Jim Martin, Dick Crutchfield (right), president of the Foundation, presented McNeill with a Certificate of Appreciation for service to the state of N.C. The SCC Foundation Dinner Theatre is held each year to raise funds in support of the college. Proceeds from the event help provide financial aid to SCC students, special educational projects, student activities and investments for future educational needs at the college. McNeill was selected as Honorary Chairperson of the 1989 Dinner Theatre.

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Nancy B. Presson, Cary
Art Minton, Charlotte
Michael A. Dente, Charlotte
Terrylynne Emery, Winston-Salem
Noel Pope, Durham
Roger D. McCollum, Rocky Mount
Harry Mallchok, Havelock
Lindsey A. Odom, Wilmington
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Coretha A. Bamberg, High Point
Margaret W. Watkins, Mebane
Christopher M. Kozma, Chapel Hill
Theodore J. Spader, Raleigh
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Nae Hong, Clayton
Cindy S. Delap, R.Ph.
Douglas P. Dove, Morehead City
Lisa Alvey Dove, Morehead City
David Jamison, Monroe
Jill M. Nelson, Greenville
Paul W. Renaud, Zebulon
Angela Campbell Yelton, Charlotte
Lynne C. Coats, Raleigh
William O. Lombard, Rockwell
R.B. Tollison, Sr., Wadesboro
John S. Calhoun, Fayetteville
Hal King, Wrightsville Beach

PharmaDates

1989

July 12—Woman's Auxiliary Board Meeting, Institute of Pharmacy
July 17—Board of Pharmacy Reciprocity Examination, Institute of Pharmacy
July 18—Board of Pharmacy Meeting, Board of Pharmacy
July 21—NCPhA Executive Committee, Omni Durham Hotel, Durham
July 21—Pharmacist of the Year Dinner, Omni Durham Hotel, Durham
August 4-6—Southeastern Officers' Conference, Williamsburg, VA
August 14—Board of Pharmacy Reciprocity Examination, Institute of Pharmacy
August 15—Board of Pharmacy Meeting, Board of Pharmacy
September 10—NCPhA Executive Committee Meeting, Institute of Pharmacy
September 18—Board of Pharmacy Reciprocity Examination, Institute of Pharmacy
September 19—Board of Pharmacy Meeting, Board of Pharmacy
September 20-21—NCSHP Fall Seminar, Greensboro
September 24—NCPhA Pharmacy Practice Seminar, Wilmington
October 11-15—Pharmacy in the 21st Century, Williamsburg, VA
October 16—Board of Pharmacy Reciprocity Examination, Institute of Pharmacy
October 17—Board of Pharmacy Meeting, Board of Pharmacy
October 21—NCPhA Endowment Fund Dinner, Kenan Center, Chapel Hill
November 11-15—NARD Annual Convention, San Antonio, TX
November 20—Board of Pharmacy Reciprocity Examination, Institute of Pharmacy
November 21—Board of Pharmacy Meeting, Board of Pharmacy
December 3-7—ASHP Midyear Clinical Meeting, Atlanta, Georgia

1990

March 10-14—APhA Annual Convention, Washington, D.C.
March 22—Socio-Economic Seminar, High Point
March 16-20—NCPhA Annual Convention, Durham
June 2-6—ASHP Annual Meeting, San Diego, CA
October 20-25—NARD Annual Meeting, Nashville, TN

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Joseph Jerome Stuccio
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You Create Culture

This is the seventh in a series of articles for professionals who manage and managers who lead professionals and those who are both. Pharmacists operate with one license, but fill many different professional roles in hospitals, chain stores, individual stores, drug companies and universities. Along the way they need a broad variety of management skills. These articles take a broad perspective on management concepts we hope you will be comfortable applying.

Curtis P. McLaughlin

Because of this series of articles, I find myself listening to guest speakers and to my students' discussions of cases with a different ear. I am increasingly shocked and disconcerted about the amount of inappropriate messages that managers send their people. Did all those articles about corporate culture go right over their heads? One of the worst failings is to create arbitrary rules that have a life of their own. It is if they did not grow up hearing "There are two ways to do every job, the right way and the Army way." *The culture that you establish for people is as important as what you do.*

Research Results

This has come home again and again in our research at UNC. One doctoral candidate studied the use of project planning and control techniques in large-scale development projects. He felt that these project planning and control techniques were important. Yet prior research found no relationship between the use of these techniques and project success. He found out why. The effect of these management tools was completely overshadowed by the effect of the quality of intergroup cooperation, the attitudes of the development group teams and people's interest in the project. Without these preconditions the management techniques mattered little, with them the techniques helped a lot.

A colleague in England and I conducted studies of how new products moved from the labs into manufacturing in the electronic instrument industries of England, West Germany, Japan and the U.S. We looked at how objective measures like R&D staffing affected profitability, product success and speed to market. We found, however, that the biggest influences over new product success were behavioral. They involved openness in working with other groups, early involvement of manufacturing in the process, and autonomy of the work groups. Top management involvement was important in getting into manufacture quickly. Cultural differences between countries were important and, although the U.S. got its products to market about as quickly as the Japanese, the products weren't as satisfactory by the time they hit the market.

Another of our doctoral candidates studied quality control in the textile industry. Again she looked at the use of many of the tried-and-true techniques of quality control and some newer ones like quality circles. Companies rated their overall quality success and she tried to relate their success back to the use of these techniques, but we had learned our lesson by now. She had also included questions on the management climate. The climate questions turned out to explain far more of the differences in quality success than the use of the quality tools.

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YOU CREATE CULTURE

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Company Experiences

You define the culture to your employees and that has a lot to do with whether things work or not. But it is more important to provide the setting than it is to decide on how things will be implemented. That is where the arbitrariness seems to come in. Two examples should illustrate the point.

At a telephone company in a nearby state service in a university town left a lot to be desired, especially in the fall when the students were coming back. The company experimented with building a project team to handle this fall rush. It included people from all the departments involved—sales, installation, directory assistance, maintenance, etc. The company's employee relations had been pretty poor. Managers were changing frequently and little trust developed. In the early meetings everyone started pointing fingers at the other departments. But gradually they got to the task at hand and set common goals and got down to problem-solving. Service improved and the company actually saved money—that was real success.

Management wanted more goodies. They said, "Let's set up more of these groups. Let's install quality circles." They put a recent graduate to work setting up the system. They told him that the circles should be formed across the work groups to get benefits like they had just experienced. He investigated quality circles and found out that they were a very different animal from the team experience that was the company's model. The circles were voluntary, they could study just about whatever interested them, and they were best initiated within work groups. The people have to work within their own groups before expanding across departmental boundaries. Even without union opposition, there was no way for them to succeed (and only 50% of circles succeed anyway), if intergroup rivalries are allowed to intrude at first.

Yet management said, "Do it across groups. That is what we need." They had had one success and that became a value.

A small North Carolina factory, part of a division of a large corporation, adopted a large, complex, expensive production planning system. It worked well and they were proud of it. There was, however, an equally effective, cheaper, simpler system to use. One day I asked the production planner why they didn't adopt the standard system called MRP. "Oh, the Division President had experienced an MRP failure at the plant he managed some years earlier. He hold us that MRP would never be used anywhere in the Corporation as long as he had any say."

What do these two experiences have in common? One positive experience and management makes an arbitrary policy. One negative experience and the other management makes an arbitrary policy. Not only did they make arbitrary rules, they stopped learning. Worse yet, they stopped their young people from learning and growing.

Rules and Learning

What does your environment say about learning. How many mistakes are you allowing? How many times does something have to happen before you make a rule. Is a rule an answer, or should everyone look behind the rule? For me a rule is there to give me a right to say no, if it is in people's best interests. It is there to be broken if I can accomplish something positive by doing so. But that isn't the way rules look to most employees. The easy out for them is to follow the rule. The lower they are in the organization, the more rules have import.

In the University we often experience arbitrary actions by state government such as hiring freezes or travel bans. Once the rule is made we find that the front line administrative managers in the university, the ones who are supposed to be on our side, enforce them with vigor. They balk when it is necessary to circumvent them to accomplish our goals, to care for patients, to teach classes, to get research done. We find we have to go back to the top people who set the rules. Their usual response is "Heavens, of course, I never intended it to work that way."

You have to expect that the rules will be much less flexible in practice than you intended them. You have to fight to avoid a culture of rules, especially if you tend to state things forcefully.

Conclusion

How then do you behave to avoid setting up a culture that is unintended. The first step is to decide positively what your culture should be. Articulate it. New managers are often hesitant to take a stand when they first arrive. They say they need more information. Yet, if they fail to state what is valued, employees will attribute values to them. They will interpret the slightest nuances in order to make sense out of your behavior.

As a manager, say to yourself, *My employees are all anthropologists.* They are observing me to determine what our culture is and what its values are. Then they will teach that to future generations. Talk and act accordingly!

DICKINSON'S PHARMACY

James G. Dickinson

The elderly to the rescue! My next-door neighbor is a 77-year-old woman who lives alone, has no family or other regular visitors, and is crippled by severe arthritis. She also has heart disease.

She represents a "silent majority" among the advanced elderly who may hold—unknown to themselves or to you—the key to pharmacy's future as a clinical profession, and to the rescue of independent practice from mail-order and HMO invasion. Demographic studies—to be confirmed in the next U.S. Census next year, I expect—show that she is being joined by millions of "reinforcements" every year, counting those who are many years younger but who already see themselves in her plight.

There will be a doubling of the over-65 population to 52 million by the year 2000 (one in six).

To protect my neighbor's anonymity, I'll call her Mrs. Gaunt. She is rarely seen any more on her front porch, even in hot weather, because the pain of moving about doesn't make it worth her while.

Mrs. Gaunt refuses to go into a nursing home; she tried that once, and was back home inside of three weeks. She has enough to pay for home care visits, but frankly her personality may be a deterrent to her forming any relationships with such visitors. In any event, the occasional help she has is soon gone. My wife goes in to check on her regularly, but we travel on business so much we're not reliable.

Most people in the neighborhood probably don't know she even exists—how could they?

Yet recently Mrs. Gaunt had a legal problem that brought her to my special attention, as her neighbor. She needed to prove that she might have been mentally compromised by her medications when she signed a document, in order to have it canceled.

I took a note of her drugs, including daily dosage directions, consulted my compendia, and made the following list:

"Meprobamate—Mrs. Gaunt's Rx is 75% of approved maximum daily dosage: common side-effects include drowsiness, dizziness, slurred speech.

"Methocarbamol—50% of maximum dosage: light-headedness, drowsiness, blurred vision.

"Acetaminophen/codeine—66% of maximum dosage: light-headedness, dizziness, sedation.

"Sinemet—60% of maximum dosage: mental changes, paranoid ideation, dementia.

"Maxzide—25% of maximum dosage: drowsiness, fatigue, dizziness, depression."

This is the kind of service any pharmacist could have done for Mrs. Gaunt—probably much more effectively than my poor effort.

Anyway, Mrs. Gaunt showed the letter to a lawyer, who charged her $100 to cancel the document, and recommended that she see a different doctor.

She showed the letter to a second doctor, who was appalled by the list and promptly stopped all of the analgesic-sedative medications, replacing them with a course of cortisone injections for her arthritis. She's 1,000% better now.

We've all read of nursing home "drug holiday" experiments under controlled conditions, and know that they work.

What Mrs. Gaunt's experience shows is that outside the nursing home, in the neighborhood pharmacy's own backyard, are other opportunities and challenges of the same kind.

All that is needed is a computer software program that links drug, strength and dosing regimen with major adverse effects and interactions. The pharmacist need not visit the patient's home—although that would be preferable—the details can be taken over the phone, and a printout like mine generated and mailed to the patient, or to

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Dickinson's Pharmacy is a syndicated column that appears monthly in many state pharmaceutical journals across the country. Mr. Dickinson is editor and publisher of Dickinson's FDA and Dickinson's PSAO industry newsletters. He has served as assistant executive director of the American Pharmaceutical Association and Washington bureau chief for Drug Topics. His home is in Morgantown, West Virginia.

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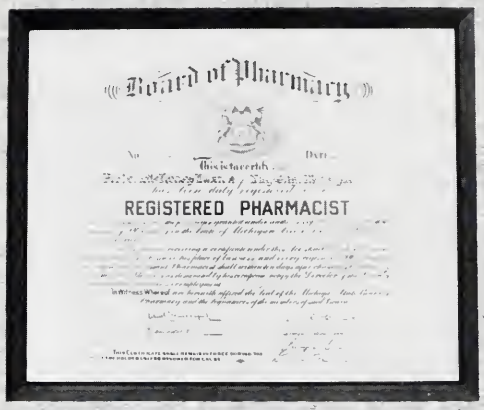

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CORRESPONDENCE COURSE
Counseling Consumers on OTC Pregnancy and Ovulation Tests

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Goals

The goals of this lesson are to:

1. describe important points about home testing products for pregnancy and ovulation; and
2. explain points of consumer information about these products to assure that test results will be accurate.

Objectives

At the conclusion of this lesson, participants will be able to:

1. select the chemical and physiological basis for which home testing products for pregnancy and ovulation are based;
2. exhibit an understanding of the reasons why false positive and false negative responses occur;
3. choose form a list of products, appropriate ones when given specific criteria;
4. demonstrate knowledge of the theory of using basal temperature measurement to predict the time of ovulation; and
5. choose from a list, points of consumer information required to correctly perform the tests.

Women can choose from a variety of OTC home testing products to determine pregnancy and to assess when ovulation will occur. These home tests are based on sound chemical and physiological principles, are relatively simple to use, and their results are accurate.

Home testing products for pregnancy and ovulation are similar in design and applicability to procedures that physicians and clinical laboratories use. But the directions must be carefully and completely followed to assure accurate test results.

Historical Perspective

Pregnancy. Fourteenth century B.C. Egyptian papyri instructed a woman who wanted to confirm her pregnancy to sprinkle urine over barley and wheat seeds. According to legend, if the barley seeds grew, she would deliver a girl. If the wheat seeds grew, she would bring forth a boy. If neither seed germinated she was not pregnant.

During the golden age of Greek medicine, Hippocrates wrote: "If a woman has not conceived, and you wish to determine whether conception is possible, wrap her up in a cloak, and burn incense underneath. If the odor passes through the body to the nose and mouth, then she is not sterile."

A 1776 English publication entitled *Aristotle's Last Legacy* proclaimed: "Keep the urine of a woman closed in a glass three days, and then strain it through a fine linen cloth. If you find small living creatures in it, she is most assuredly conceived with child; for the urine which is before part of her own substance will be generated as well as its mistress."

The biological era of urine testing for pregnancy began in 1928. The test procedure utilized animal tissues to detect the presence of human chorionic gonadotropin (hCG) in the urine. This hormone is produced by the placenta after an ovum (egg) has been fertilized and implanted in the endometrium. Its function is to maintain the corpus luteum and keep progesterone production relatively high to support vascularization of the endometrial wall. It also curtails pituitary production of follicle stimulating hormone (FSH)

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CORRESPONDENCE COURSE

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and luteinizing hormone (LH), thereby preventing another ovum from being released and competing with the developing fetus.

The test was performed by injecting the woman's urine into a female rat. The animal was sacrificed after 5 days, and its uterus removed and weighed. A heavy uterus indicated that hCG was present in the urine, and hence, that the woman was pregnant.

Over the years, other animal species were substituted for the rat because they required less time to complete the test. For example, rabbits displayed a similar response in 48 hours. African toads responded within a few hours after injecting urine containing hCG by laying eggs or releasing sperm, depending on their sex.

The disadvantages of biological assays are obvious. Sacrificing animals is expensive, and some believe unnecessarily cruel. African toads are difficult to obtain. And biological assays are plagued with the same broad variability of results associated with other forms of animal experimentation. Animal tests also yield a high false negative response rate.

The modern immunochemical assays for detecting pregnancy replaced the older methods beginning in 1960. They are cheaper, generally require only minutes to a few hours to perform, and are more accurate.

Ovulation. Through the years, women have also attempted to predict their time of ovulation by using a variety of evaluative means. None were reliably accurate. Basal (resting) metabolic temperature measurement has been used as a predictor since the early 1900s. A rise in the basal body temperature occurs approximately one day after the surge of LH from the pituitary.

Recall that LH is the hormone that initiates the mature graffian follicle in the ovary to release an ovum into the fallopian tube to await fertilization. It also supports the corpus luteum which, in turn, secretes high levels of progesterone to make the endometrial lining more receptive to implantation and to maintain growth of the fertilized ovum. Following conception, hCG assumes this role.

The problem is that information obtained by measuring the basal metabolic temperature only suggests that a woman has already ovulated, approximately one day earlier. Although basal metabolic temperature monitoring has been widely used and is simple to perform, the procedure has limited value and results are subject to considerable error.

Basal Temperature Measurement. The **basal temperature** is the lowest body temperature that occurs while awake. In healthy women, it is recorded upon awakening from a restful sleep, before initiating mental or physical activity.

The basal thermometer measures body temperature between 96° to 100° F. By limiting the range of temperature readings, there is a wide span between each 0.1° mark on the thermometer. This makes it easier and more accurate to measure slight temperature variations.

For the first fourteen or so days of each menstrual cycle, the basal temperature fluctuates only slightly. When ovulation occurs, the temperature first drops 0.4° to 1°, then spikes 0.5° to 1° above the preovulation period. It remains elevated until menses occurs.

To properly use the basal temperature ovulation testing method, the woman should chart her daily body temperature for at least 4 months to get a control level. She should take it immediately on awakening, before arising from bed, drinking, talking or smoking. A chart is supplied with each basal thermometer and should be used as instructed.

The woman should be advised to shake the thermometer down to a reading below 95.5° the night before each reading, since any degree of physical activity can affect the basal temperature. The thermometer can be used orally or rectally, but the former is preferred. It should remain in place for 5 minutes, before removing and the reading recorded.

Numerous other assessments have also been employed by physicians to predict timing of ovulation. These include determining changes in the morphology of the cervix and assessing its quantity and quality; measuring estrogen, progesterone and LH levels; and detecting temperature changes on the breast. All of these methods have some utility and are applicable to specific situations. But assaying for urinary LH has proven to be the most useful of all of the tests, and this serves as the foundation for modern OTC ovulation testing products.

OTC Ovulation Tests

The physiological basis for these self-tests is that ovulation normally occurs at midcycle, fourteen days after onset of the previous menses. It is triggered by a sudden surge in release of LH from the pituitary, which spikes approximately 24 hours prior to ovulation. This increased concentration spills over into the urine where it can be detected.

Table 1

OTC Ovulation Testing Products

Product	Manufacturer
First Response Ovulation Predictor Test	Tambrands, Inc.
OvuSTICK Self-Test	Monoclonal Antibodies, Inc.
Ovutime	Ortho Pharmaceutical Corporation
Q Test for Ovulation Prediction	Becton Dickinson

OTC tests for ovulation (Table 1) enable women to predict when they will ovulate. This information can be used to increase the chance of pregnancy. By knowing when ovulation is most likely to occur, coitus can be planned accordingly.

They can also be used to assist in minimizing the chance of pregnancy. Coitus can be avoided, or extra contraceptive measures taken during the fertile period.

The products share an important limitation when used to avoid pregnancy. An unwanted pregnancy can occur, even though the testing product accurately predicted the time of ovulation. Sperm remain viable within the female genital tract for up to 72 hours. If the test predicted on day 13, for example, that ovulation would occur on day 14, sperm that had been deposited as early as day 11 might still fertilize an ovum 3 days later. Also, unprotected coitus should be avoided for 3 days following ovulation to minimize the chance of pregnancy.

OTC Pregnancy Tests

If an ovum is fertilized and becomes implanted in the endometrium, sufficient hCG will be produced so that detectable amounts can be found in the woman's urine within about 9 days. By this point she has not missed a period because menses would not normally occur for another 5 days. Human chorionic gonadotropin production doubles every 2 weeks to peak at the 8th to 10th week of pregnancy. The level then decreases afterward. The hormone is a specific marker for pregnancy, because in healthy women, it is only synthesized in significant amounts by the placenta.

Hormone levels are highest in the morning between 9:00 a.m. and noon because renal activity is greatest during this time. Manufacturers of home testing products recommend that an early morning urine sample be used to assure the most accurate results.

Urinary hCG can increase even in the absence of pregnancy, when chorionic tumors such as hydatid disease or choreocarcinoma are present. OTC testing products will detect such tumors in females, and in males who have choreocarcinoma of the testes. The hormone is not normally present in significant amounts in males after birth. Therefore, its quantification provides a useful measure of tumor progression or regression in men.

It should be noted that an accurate test for early detection of pregnancy must be sensitive, but at the same time provide minimal false negative and false positive responses. To be competitive among other products, the test must be easy to perform in a short period of time, be readily available, be easily reproducible and relatively inexpensive.

Early pregnancy detection can help a woman avoid drugs and chemicals, and exposure to x-rays or elective surgery that are potentially harmful to the fetus. Cellular differentiation and development of embryonic organ systems occur during the first trimester of pregnancy, and the fetus is most susceptible then to toxicity. The first 8 weeks are the most critical, and neither the woman nor her physician may be aware of her pregnancy status that early.

The earliest home pregnancy testing products contained **polyclonal** antibodies that recognized several binding sites on hCG. They were also reported to react with other substances such as LH and FSH, to give false positive results.

Newer pregnancy testing products (Table 2) employ state of the art **monoclonal** antibody technology. Monoclonal antibodies are sensitive to a single binding site on the hCG molecule. They do not react with other substances and they are more accurate.

OTC pregnancy tests can be grouped as first or second generation products. **First generation tests** work on the principle of hemagglutination inhibition. To use them, the woman incubates a urine sample with test product reagent that includes sheep RBC's coated with hCG and rabbit anti-hCG serum. If hCG is present in sufficient

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concentration to neutralize the antiserum, the RBCs will not agglutinate. Instead, they will settle to the bottom of the test tube in a doughnut-shaped pattern indicating a positive test. If the antibody is not neutralized (negative test), agglutination results in a diffuse mat of cells at the bottom of the tube. The most sensitive of the first generation home testing products detects hCG as early as the third day of a missed menstrual period.

The **second generation OTC pregnancy testing products**, which are even more sensitive, utilize monoclonal antibodies and detect hCG as early as the first day of a missed menstrual period. Whereas the first generation tests require up to 60 minutes to perform, one of the newer tests requires only 10 minutes to obtain a response. Second generation testing products are also generally easier to use.

How Accurate are the OTC Pregnancy Tests?

Some manufacturers' package inserts claim their products possess an accuracy of approximately 98 percent, even when the tests are performed by women who are untrained in diagnostic procedures. There are numerous factors which may lead to underlying false negative or false positive results. Table 3 summarizes important points. The most common cause of a false negative response is performing the test too early or too late in gestation when hCG levels may be insufficient to detect. Manufacturers advise users who obtain a negative test to confirm the result by repeating the test one week later.

False positive test results can be caused by contamination of the reagents or urine collection containers. In the case of a missed or incomplete abortion, a significantly elevated hCG level may remain in the urine for 1 to 2 weeks afterward. A test performed at this time will yield a false positive result.

The first generation tests do not distinguish between gonadotropins from pituitary or chorionic origin. Post-menopausal women and others who take drugs which stimulate hCG production may get a false positive response. False positive responses are rare with the second generation testing products. Some phenothiazine derivatives (e.g., Thorazine, Stelazine, Trilafon, Vesprin, and Mellaril) are documented causes of false positive results with the hemagglutination inhibition tests. Phenergan has been reported to cause a false negative result with these tests.

A major deficiency of the home pregnancy and ovulation testing product is a lack of quality control in the reagents used. Test kits should ideally contain one control reagent which would provide a positive test, and another which would give a negative result. These controls would allow the user to check the test product's reagents for stability and sensitivity.

An interesting question regards whether a woman can accurately assess if she is pregnant, without using a diagnostic test. In other words, are the tests more accurate than female intuition?

The answer, 283 women who requested a pregnancy test from a physician because of late menses were questioned as to their feelings about the possibility of pregnancy. Two hundred four (74 percent) of the women believed they were pregnant, but only 109 (53 percent) tested positive. Of the women who believed they were not pregnant, 90 percent were accurate.

Counseling Consumers

OTC testing products for pregnancy are not intended to replace a physician's diagnosis. Manufacturers' instructions strongly stress that users contact a physician immediately if they get a positive test result. This should be reinforced to all OTC pregnancy testing product purchasers. Users should also be told to consult a physician even though they obtain one or more negative test results, if they still think they are pregnant, and their menstrual period is more than 7 days overdue. A negative urine test result merely implies that hCG is not present in detectable

Table 2

Selected Newer Home Testing Products for Pregnancy

Product	Manufacturer
Advance	Ortho Pharmaceutical Corporation
Answer Plus	Carter Products
Clearblue	VLI
e.p.t. Plus	Warner-Lambert Company
First Response Pregnancy Test	Tambrands, Inc.
Q Test for Pregnancy	Becton Dickinson

Table 3

Factors That Interfere with Home Pregnancy Test Products

False Negative Responses
- Test conducted too early or too late during gestation
- For first generation tests: test tube and reagents jarred during the incubation period

False Positive Responses
- Soap or detergent residues in the urine collection container
- Blood or protein in urine*
- Test conducted in missed or incomplete abortion
- Ectopic production of hCG by non-trophoblastic tumors (e.g., carcinoma of lung)
- Test conducted in postmenopausal women
- For first generation tests: drugs such as phenothiazines and oral contraceptives (see text)

*Not significant for second generation test products

quantity. It does not mean that the woman is not pregnant. A positive response indicates a probable, but not absolute, sign of pregnancy.

Pharmacists can provide a professional service by explaining to consumers how the testing products work and making sure that they understand the variables which may lead to erroneous results. It is unfortunate that not all of the products list these factors in their directions.

Women should be instructed to read and follow directions carefully, and to ask a pharmactist or physician for assistance if some steps are not clear. Instructions for using the home testing products are not interchangeable among different products. Some pregnancy testing products instruct the user to gently shake the reagents, for example, while others state that the user should shake the reagents vigorously. Still others state that they should not be shaken at all.

It is best to use early morning urine samples. These contain the highest concentration of hCG and LH, assuming the bladder has not been emptied for the past 6 to 8 hours. Urine should be collected in a clean, dry, detergent-free container, preferably the one supplied with the product. It should be tested immediately after collection. If this is not possible, urine may be refrigerated for up to 12 hours before testing.

If refrigerated, urine should not be frozen, as hCG and LH can be denatured upon thawing. It should not be shaken if a sediment occurs. Instead, the clear upper (supernatant) portion should be removed for testing. Urine that is colored pink or red, appears cloudy, or has a strong odor should not be used.

Vibrating the tube or exposing it to direct sunlight during the waiting period may affect formation of the ring for the first generation tests. The tube should, therefore, not be left on or near a vibrating appliance such as a refrigerator, dishwasher or food processor.

Correspondence Course Quiz on page 36.

Correspondence Course Quiz

OTC Pregnancy Tests

1. OTC urine pregnancy testing products detect which of the following substances?
   a. Chorionic gonadotropin
   b. Estrogen
   c. Luteinizing hormone
   d. Progesterone

2. After a fertilized ovum becomes implanted in the endometrial wall, measurable amounts of the substance referred to in question #1 can be found in the urine approximately:
   a. 24 hours later.
   b. 72 hours later.
   c. 9 days later.
   d. 28 days later.

3. The best time to collect a urine sample for OTC pregnancy or ovulation testing is:
   a. after a 4-hour fast.
   b. early in the morning.
   c. midday, after the second voiding.
   d. just prior to going to bed.

4. Basal metabolic temperature measurement to predict ovulation is based on a:
   a. rise in resting body temperature that occurs one day before the surge in LH release from the pituitary.
   b. reduction of resting body temperature that occurs one day before the surge of hormone release from the pituitary.
   c. rise in resting body temperature that occurs one day after the surge of LH release from the pituitary.
   d. reduction in resting body temperature that occurs one day after the surge of LH release from the pituitary.

5. Which of the following trade names applies to both a pregnancy test and an ovulation test?
   a. Advance
   b. Clearblue
   c. Answer Plus
   d. First Response

6. If a urine sample cannot be used for pregnancy testing immediately after voiding, it should be:
   a. stored in a refrigerator.
   b. kept at room temperature.
   c. frozen and thawed out later.
   d. discarded.

7. OTC urine ovulation testing products detect which of the following substances?
   a. Chorionic gonadotropin
   b. Estrogen
   c. Luteinizing hormone
   d. Progesterone

8. The pregnancy tests that are reportedly more accurate employ:
   a. monoclonal antibodies
   b. polyclonal antibodies

9. The phenothiazine derivative that has been reported to cause a false negative response with first generation pregnancy tests is:
   a. Thorazine
   b. Mellaril
   c. Phenergan
   d. Stelazine

10. The hormone that makes the endometrial lining more receptive to implantation of a fertilized ovum is:
    a. chorionic gonadotropin.
    b. estrogen.
    c. luteinizing hormone.
    d. progesterone.

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DICKINSON'S PHARMACY

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anyone else the patient requests (i.e., a physician or attorney).

It would be good to have a more sophisticated package that took into account the patient's current weight, known allergies, disease conditions, and other data for a complete profile—and established pharmacy patient profile systems can do that. However, the Mrs. Gaunts of this world are presumed not to be already known to the pharmacy in this way—perhaps they are receiving mail-order medications, or are dependent on people bringing them their medicines from whatever pharmacy the visitors use.

(Mrs. Gaunt patronizes a chain drug store, and pays messengers to pick up her prescriptions.)

To be truly effective, a year-round outreach program needs to be maintained in the community—perhaps through the local cable TV system, senior citizen's center, etc. Handled well, such a system could be the biggest development in pharmacy.

If any reader would like to know more about this, or offer suggestions, please let me know directly. Write P.O. Box 848, Morgantown, WV 26507-0848, or call me at (304) 291-6690.

This feature is presented on a grant from G.D. Searle & Co., in the interests of promoting the open discussion of professional issues in pharmacy. G.D. Searle & Co. accepts no responsibility for the views expressed herein as they are those of the author and not necessarily those of G.D. Searle & Co.

SCHERING REPORT X

Continued from page 5

On the basis of hours worked, men are paid $16.80 an hour, with women earning slightly less at $16.52, "statistically not a significant difference . . . pointing out that contributions of both men and women pharmacists are equally recognized and equally rewarded."

Schering Report X also explores how pharmacists view their compensation, work practices and environment, and their evolving role as "physicians' surrogates" in selecting generic drugs, counseling consumers on minor ailments and recommending over-the-counter medications.

A booklet summarizing the Schering study is available by writing: Pharmacy Affairs Department, Schering Laboratories, Kenilworth, NJ 07033.

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NCPhA's 109th President, 1989-90, Ralph Hilliard Ashworth

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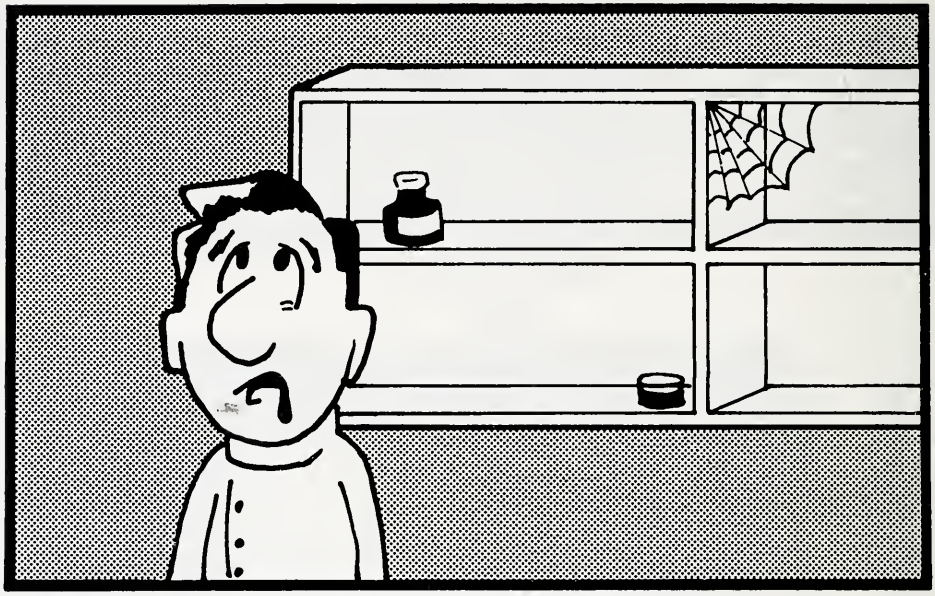

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PRESIDENT'S REMARKS

Ralph Ashworth, the 1989-90 President of NCPhA, delivered the following acceptance speech at the Recognition Luncheon during the 109th Annual NCPhA Convention on May 20, 1989. These remarks will begin the monthly commentary from our new president.

It is with a great deal of pleasure and honor that I accept the president's gavel of the N.C. Pharmaceutical Association. I have pledged to all of you that I will do my best to uphold the integrity and traditions of our association. I ask for your support in this pledge.

Back in 1955 when Al Mebane, I and others were walking down Rosemary St. from the Kappa Psi house to the Institute of Pharmacy to take the state board, I never dreamed that 34 years later I would be installed as the President and Al would be serving as our executive secretary of our association. During these 34 years of pharmacy practice, pharmacy has been good to my family and me. I want to thank our association for having a large hand in this success and making today possible.

Our association is 109 years old and sometimes we may take it for granted, but we did arrive here today for this meeting of NCPhA by ourselves—this didn't "just happen." We got to this point in our history by countless pharmacists who persisted in their dedication and service to our profession. This is a building process, and this year we add another block to our distinguished association's heritage.

We can be proud that we have over 2700 pharmacist members in our association, but we can improve on this knowing that there are many who are not members. I think we realize that one voice on a major issue may not be heard but many voices, with the backing of a strong association, is more likely to get attention. This is one of our goals for this year—meaningful membership—that is, an active member that has a real concern for pharmacy. The days of ignorance and apathy are over; today we must be informed and active pharmacists.

We certainly have no shortage of issues facing us today—some of which are changing the practice of pharmacy that we have known for so many years. We know what some of these issues are: third-party reimbursement, freedom of choice, physician dispensing, mail order pharmacies, discriminatory pricing, excessive government regulations, and many others. We cannot solve these problems alone, but with a strong group dedicated to providing the best prescription delivery system and the protection of public health, we will have a better chance of success.

The chairmen of our standing committees have been appointed, and Vice-President Burton will soon be appointing chairmen-elect for next year. We hope these committees will get an early start on their work programs and be reporting to our executive committee on their progress. I trust each of you has signed up for a committee that has a special interest to you. We ask for your support in all our endeavors this year and that you will be an active participant.

Our association has been blessed through the years with an excellent staff. For many years WJ and Vivian Smith did an outstanding job. Today we are proud and grateful for Al and Betsy Mebane and their staff for providing all the services rendered to our members. They are the glue that holds us together. We thank Al and Betsy, Erie Cocolas, Kathryn Jefferson, and Terri Little for a job well done.

I thank you for being here today and I ask for your continued support through the year.

Thank you.
Ralph Ashworth
1989-90 NCPhA President

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NCPhA 1989 ANNUAL CONVENTION BREAKS RECORDS

The Myrtle Beach Hilton was the site of the 109th Annual Convention of the North Carolina Pharmaceutical Association in Myrtle Beach, South Carolina, May 17-21, 1989. As expected, this year's Beach Convention Vacation was the most well attended NCPhA convention in recent years. A total of 507 persons registered for the annual convention which included Woman's Auxiliary members, the Traveling Member's Auxiliary, students from the UNC-CH and Campbell University Schools of Pharmacy, and exhibitors.

Convention Organizers

Tom Burgiss of Laurel Springs was the Convention Manager and Loni Garcia of Graham, the Convention Registrar. Both worked together to insure that all events ran smoothly and on schedule.

Opening Night

The Convention opened Wednesday evening with a reception honoring the outgoing presidents of the NCPhA and auxiliary groups—Al Lockamy, Jr. of Raleigh, president of NCPhA, Mrs. Alan (Rose) Boyd of Kenly, president of the Woman's Auxiliary, and Tom Terry of Wilson, president of the Traveling Member's Auxiliary. Following the reception, conventioneers attended a formal banquet in the hotel's Grand Ballroom. The 75th Annual Convention of the Traveling Member's Auxiliary, the 62nd Annual Convention of the Woman's Auxiliary, and the 109th NCPhA Annual Convention were called to order by each of the reigning presidents. Greetings of welcome were extended to the convention group by Carol V. Bateman, president of the South Carolina Pharmaceutical Association. (The Myrtle Beach Hilton was the site of the 1988 SCPhA Annual Convention. As a return gesture, the 1989 SCPhA Annual Convention, June 24-27, will be held at the Grove Park Inn in Asheville, site of 1988 NCPhA Annual Convention.)

The dynamic and award-winning Robert H. Henry was the featured speaker for the evening. His motivating talk entitled, Win With A.C.E.S., i.e., an optimistic Attitude, a Commitment to pharmacy, Enthusiasm towards your profession, and Service to the public and the profession, was an appropriate beginning to the convention.

For the evening finale, several coveted awards were presented. The Don Blanton Award was presented by Charlie D. Blanton Jr. of Kings Mountain in memory of his father who was president of NCPhA in 1957. The award was bestowed upon Jimmy Jackson of Garner for his contributions to the advancement of pharmacy in North Carolina. Jackson is the chairman of the State Legislative Committee of NCPhA. He has been employed at Kerr Drugs since 1962 and holds the position of the Director of Pharmacy Operations for the regional chain. He has been active in the Pharmacy Network and the NC Merchants' Association and past chairman of the Merchants' Association's Chain Store Lobbying Committee. In Blanton's words, "Jackson was active in providing information, input and muscle when required."

Joe Whitehead, Vice President of Corporate Affairs for the Burroughs Wellcome Co., honored incoming NCPhA president, Ralph Ashworth of Cary, with a navy blue blazer bearing the NCPhA coat of arms. This newly added distinction for incoming presidents was initiated last year by the Burroughs Wellcome Company.

Last but certainly not least, the NC Pharmacist of the Year Award was presented to L. Milton Whaley. Whaley is president of the Board of Directors of the newly incorporated NCPhA Endowment Fund and chairman of the Finance Committee. Whaley was honored for his excellence in professional practice throughout his 38 years as a pharmacist in N.C. as well as activities in the Association and community affairs. A dinner in his honor will be held later this summer in his hometown of Durham.

Business Sessions

The annual Rite of the Roses, a memorial ceremony for those members who have died since the last convention, marked the beginning of the Business Sessions on Thursday morning. Third Vice President Robert Worley and his wife, Mary Lou Worley, led a commemorative prayer.

Each morning, the Business Sessions featured both educational presentations and reports from various pharmacy groups. Walter Fitzgerald, J.D., Executive Director and General Counsel for the American College of Apothecaries, Jean P. Gagnon, Ph.D., Director of Pharmacy Relations, Marion Laboratories, Kirk Ways, M.D., endocrinologist specialist at the East Carolina School of Medicine, and Jan H. Phillips, Ph.D., assistant professor, Division of Pharmacy Administration, UNC-CH School of Pharmacy, gave excellent presentations ranging from legal issues associated with expanded pharmacists' roles to the results of a survey commissioned by

Continued on page 8

CONVENTION BREAKS RECORDS

Continued from page 7

NCPhA examining N.C. pharmacists' salaries, benefits, working conditions and job satisfaction.

Reports were given by Dean Tom S. Miya, Ph.D., and Amy Greeson, president of the Academy of Students of Pharmacy (ASP) of the APhA UNC Student Branch, both of the UNC-CH School of Pharmacy; Dean Ronald Maddox, Pharm.D. and John Boyd, president of ASP, Campbell University Student Branch, both of Campbell University School of Pharmacy; Andy Barrett, Executive Director of the Pharmacy Network of N.C.; and David R. Work, Executive Director of the N.C. Board of Pharmacy. In addition, each NCPhA committee chairman had an opportunity to report on the progress of their respective committees.

Awards

The Marion Laboratories "Young Pharmacist of the Year" distinction was awarded to Sarah Beale Cobb, community pharmacist at Town Center Pharmacy in Southern Pines. Cobb serves as secretary for the Moore County Pharmaceutical Association and is currently chairman of the Public and Professional Relations Committee of NCPhA. She is a former co-chairman of the N.C. Pharmacy Week Steering Committee. Jean Gagnon, Ph.D. presented the award on behalf of Marion Laboratories.

Max Gardner Reece of Siler City was honored by NCPhA as its 1989 recipient of the A. H. Robins "Bowl of Hygeia Award" for outstanding service. The award was presented by Michael E. Winters, Divisional Sales Manager, A. H. Robins Co. Reece has served two years on the NCPhA Ethics Grievance & Practice Committee and was inducted into the prestigious N.C. Academy of Pharmacy in 1987 for his professional and civic activities. He has also served as a pharmacy preceptor for pharmacy student interns. In the fall of 1988, Reece ran on the Republican ticket for a seat in the N.C. senate.

The McKesson Presidential Award was presented by Larry W. Ogden, District Sales Manager of the McKesson Drug Company of Cayce, S.C. to incoming NCPhA president, Ralph Ashworth.

Other pharmacist achievers were honored for their fifty years of professional practice. Lapel pins and certificates were presented to those who were licensed to practice pharmacy in 1939 at the Recognition Luncheon on Saturday. Inducted into the "Fifty Plus Club" were Shelton B. Boyd of Mt. Olive, Michael Dente of Charlotte, Luther Kenneth Edwards, Jr. of Stantonsburg, James Hamilton Fox of Asheboro, Aldridge Kirk Hardee, Jr. of Charlotte, George Haywood Jones of Zebulon, Ernestine B. Lynch of Dunn, John Ivey Thomas of Dunn, Joseph Peyton Tunstall of Washington, and Barney Paul Woodard of Princeton.

Exhibitors' Fair

On Friday afternoon 100 exhibitors participated in the fifth NCPhA Convention Exhibitors' Fair. The large number of exhibitor participants was a record breaking number. A total of 45 exhibits were displayed.

Entertainment

If the beautiful S.C. beach wasn't enough to keep you preoccupied in your spare time, numerous other choices abounded. The Annual Golf and Tennis Tournaments were held on Thursday afternoon. Dancing to the music of The Embers took place later that evening. On Saturday evening, all assembled to enjoy a luau and the Hawaiian entertainment group, Lei Aloha's Polynesian Revue.

Sunday Seminar

The convention closed with an all-day seminar on Sunday sponsored by NCPhA and the UNC-CH School of Pharmacy. Over 200 persons attended the seminar to learn about "The Pharmacist's Role and Responsibility in Health Promotion and Disease Prevention."

LOCAL DELEGATES ARE RECOGNIZED DURING NCPhA CONVENTION

This year, each local association was asked to designate a representative to appear at NCPhA's 109th Annual Convention in Myrtle Beach. The following persons were recognized as "official" convention delegates during the Second Business Session and attended the V.I.P. Breakfast on Thursday morning, May 18, along with NCPhA officers and past presidents and other special guests.

Larry Brown	Guilford County Society of Pharmacists
Lamar Morse	Wake County Pharmaceutical Association
Tom Taylor	High Country Pharmacy Association
Logan Womble	Northeastern Society
Robert Worley	Wayne County Pharmaceutical Association

1988-89 NCPhA PRESIDENT'S REPORT

May 18, 1989—a day that seemed so far away last year when I was installed as president of NCPhA in Asheville. Yet, today, is my last address as your NCPhA president. And now, as I look back I feel good about how NCPhA has progressed this past year.

NCPhA has had positive growth in many areas. Over the past year, for example, our membership has increased to the point that it is now approaching 2,700 members. Among state associations, NCPhA is ranked 5th in size, yet we have the smallest staff. (I think this speaks well of our capable staff: Al, Betsy, Erie, Teri and Kathryn.) More pharmacists than ever volunteered to participate on committees and more NC pharmacists are involved with committees in national organizations such as APhA, NARD and ASHP. Attendance is also up at NCPhA meetings and C.E. programs. This annual convention has even attracted larger than usual crowds.

Many of these accomplishments were mandated by resolutions at last year's convention. It gives me great pleasure to report to you the status of these resolutions at this time. Last year's convention recommended we look at several issues which affect the make-up of our association and how it operates. Included were:

1. a House of Delegates,
2. a revised Executive Committee structure, and
3. a method of amending NCPhA's Constitution and By-laws.

Committees were assigned to study these issues. Their reports will be given during this convention. Please read and listen carefully to their conclusions and recommendations as the chairman presents his or her report so that you will have a clear idea of the direction our association will take from here. Your input and comments are also important.

One of the most exciting projects of the year was NC Pharmacy Week—a joint venture between NCPhA and NCSHP chaired by NCPhA's Linda Griffin of Glaxo, Inc. and NCSHP's Leslie Mackowiak of Duke Medical Center. The "Ask Your Pharmacist" phone-in was well received by the public and professionals, alike. We also received good publicity on the radio and TV—and even national coverage for our efforts. Special thanks to Glaxo, Inc. and the Burroughs Wellcome Co. for their financial support and advice.

This successful project, which involved a joint effort between community pharmacists, hospital pharmacists and academia, emphasized to all of us that many of our concerns and goals for pharmacy are the same. Together, we *can* achieve greater success through *cooperation*. Hopefully, we will see more projects of this same caliber and spirit of unity in the future.

Besides being a busy year for the association I, too, have been a busy president. As your president I have attended over 100 meetings covering greater than 25,000+ miles. The journeys on behalf of NCPhA have taken me from Wilmington, NC to Anaheim, CA, from Atlanta, GA to Indianapolis, IN and from Tampa, FL to Washington, D.C.

It was a pleasure to represent such an outstanding association at these meetings, but I could not have done it without the support of the company for which I work. Revco has encouraged and supported me as I served the association.

In closing, I would like to thank all the pharmacists who supported our profession by attending the Superior Court hearing on the Charlotte Memorial Hospital vs. NC Board of Pharmacy in Raleigh on April 6, 1989. Seldom has a profession been so unified and spoken with one voice of harmony.

I also want to thank my wife and children for their support during the year.

Yes, it has been a good year for our association and for me. There are many, many persons to be thanked—a list too long to be named. However, to each of you on the Executive Committee, I appreciate all that you have done to help me serve as your president. And to all of you members, thank you for allowing me to have the opportunity to serve as the president of the finest state association in this country—the North Carolina Pharmaceutical Association!

Thank you.

Albert Fulton Lockamy, Jr.
1988-89 NCPhA President

July, 1989

REPORT OF CAMPBELL UNIVERSITY SCHOOL OF PHARMACY

Presented by Ronald W. Maddox, Pharm.D.
Dean, Campbell University School of Pharmacy

ACCREDITATION

An evaluation team from the American Council on Pharmaceutical Education (ACPE) recently evaluated the professional program of the Campbell University School of Pharmacy for the purpose of candidate status accreditation. The evaluation team which visited the Campbell University School of Pharmacy consisted of Dr. Daniel Nona, Executive Director, ACPE; Dr. Arthur Nelson, Dean, Idaho State University College of Pharmacy; Mr. Michael Hart, Board of Directors, ACPE; Dr. Curtis Black, Associate Professor, Purdue University School of Pharmacy; and Mr. William Adams, Vice-President, North Carolina Board of Pharmacy. The team was of the opinion that intense planning and implementation had occurred in the School, and that the School of Pharmacy is well established for candidate status accreditation. They will present their findings at the ACPE Meeting in June and recommend candidate status accreditation at that time.

TRAINING SITES

Currently 47 third-year students are being trained in community pharmacies and hospitals in close proximity to our campus. A number of these students will be involved in their fourth-year training in June. Affiliations for this fourth-year training program has been developed in numerous sites throughout the state. Also, Gerald Stahl has joined our faculty as fourth-year clerkship coordinator.

RESEARCH

Research activities are ongoing in the School of Pharmacy. Numerous faculty and students are involved in a wide scope of research endeavors. Of particular significance is the receipt of our *first* federal research grant. Dr. Kathy Webster recently received a $75,000 grant from the National Institute of Environment Health Sciences to evaluate the toxicity of diethylhexylphthalate (DEHP).

FACULTY

The faculty of the School of Pharmacy consist of nineteen full-time faculty members. The School also has a volunteer faculty of 46 registered pharmacists who function as preceptors in community, hospital, and nursing home training sites. This faculty has done an excellent job in meeting our third year curricular needs.

The School of Pharmacy has six additional positions projected for next year bringing the total faculty to twenty-five. Faculty will be employed in the following disciplines: pharmacy administration, pharmacokinetics, nutritional support, oncology, and internal medicine (2). Three of these individuals have already been employed and the remainder will be hired during the year.

ENROLLMENT

The enrollment in the School of Pharmacy is 179. We will add our fourth class of 65 students this fall bringing the enrollment to 244. We also have 122 pre-pharmacy students on campus.

The percentage of students completing their pre-pharmacy education at Campbell University continues to increase each year. Twenty-three Campbell students entered the School of Pharmacy in the Fall of 1988 and twenty-eight have been accepted for the Fall of 1989.

ADMISSIONS

Our applicant pool has continued to increase each year. (Totals: 1986—127; 1987—202; 1988—282). We currently have 283 applicants for the Fall of 1989, sixty-one (61) of whom have been accepted and paid a deposit to reserve their place in the next class.

The School of Pharmacy has been fortunate in being able to attract students of high academic caliber during its short history. Overall grade point averages of 3.2 for the first two classes and 3.3 for the third class are well above the national average for entering pharmacy students.

PROFESSIONAL ACTIVITIES

Our faculty and students are involved in a wide range of professional activities. Mr. William Strozyk, a third-year student won first place in the Searle Fellowships in Pharmacy Award Program. The program recognizes outstanding individuals enrolled in a Doctor of Pharmacy program within the United States. Bill received a $7,500 check, a plaque, and a $750 stipend for travel. His faculty mentor, who received $2,000

Continued on page 37

REPORT OF THE ACADEMY OF STUDENTS OF PHARMACY (ASP) OF THE APhA, Campbell University School of Pharmacy

presented by John Boyd, President

Campbell University School of Pharmacy has completed its third year of existence and excellence. The student branch at Campbell boast of completing its third year of successful recruiting. For the third consecutive year we had 100% membership in the North Carolina Branch. We are also proud of our 80% national membership. Although ASP at Campbell is a young organization, we are striving to make it successful. We are already planning an active recruitment for the upcoming year, by sending pamphlets describing the organization out to the incoming 3/6's.

To keep membership high you must be active in service projects, social projects, and conventions. We participated in several service projects this year. Members of the student branch helped out in a blood pressure clinic in an adjoining town. We also gave a hand at Buies Creek Elementary School with a Halloween carnival in the Fall and a Spring Carnival last semester. The Spring Carnival was fun for us, as well as the children. Our Dean, Dean Maddox, was a good target in the dunking booth. These projects allowed us to interact with the community and gain their respect. Some members also helped out at Career Day.

One school project that really impressed faculty and students, myself included, was the Patient Counseling Competition. This competition enabled students to apply their knowledge of drugs and actually practice the valuable skill of patient counseling. Good patient counseling is very important in maintaining the image of pharmacy, providing effective drug therapy, and to improve the safety of patients. The competition was such a valuable learning experience that there has been an effort to provide an elective in this skill. We hope to get this elective approved for next year. If plans work out this class will also be offered for CE credit sponsored by the student branch. The finalists of this year's competition were presented USPDI's. Joe Moose, our former President, was the winner and represented us well in Anaheim, CA, at the National Competition.

Several weeks ago we continued a tradition at Campbell by giving two awards. The Student Branch presented a Teacher of the Year Award to Mrs. Paula Thompson. The other award was given to Mr. Steve Wilson, a Glaxo representative that has helped out the organizations at Campbell University School of Pharmacy.

Not only were we involved in the Buies Creek Community, but we also attended several conventions. Six students represented us at the regional meeting in Columbia, SC, while fifteen students attended the APhA Annual Convention in Anaheim, CA. Anaheim, CA, was something to remember for me. Not only was it my first (scary) airplane ride, but we really met some nice people and had a good time. A few of us were up early and red-eyed for that early morning North Carolina breakfast, which gave us a chance to see exactly what NCPhA has their hands in.

We were quite proud when a member of our charter class, William R. Strozyk, received the pretigious Searle Fellowship Award. Strozyk received $7500 and his mentor, Dr. Fred Cox received a $2000 award. He was judged in (1) his vision for the profession of pharmacy, (2) leadership potential, and (3) professional development, and (4) educational achievement. His winning essay was on patient counseling which as I said before is important. We were well represented by our delegates at the meeting. The delegates as well as the rest of us came back to the "Creek" enthusiastic and anxious to put to work some of the new ideas we gathered in California.

One idea that we bought back from California was the combination fundraiser-educational event of a Drug Fair. A Drug Fair will take a lot of work, but we hope to get one started in the upcoming year. We'll invite drug companies and chains to interact with the students and faculty by answering questions concerning drugs and careers.

Next year promises to be a good one with work on old projects continuing and new ones such as the Drug Fair beginning. Plans are already beginning for a trip to the regional meeting in Gainesville, Fla. and the national meeting in Washington, DC. We hope to get up a big crowd to go to Washington.

A very important thing will be happening at Campbell next year. We will be graduating our first Pharm.D. class. We will all be very proud of this class and hope we can get them to stay involved by joining the NCPhA. This class will have our full support as they leave to represent

Continued on page 37

REPORT OF THE UNC SCHOOL OF PHARMACY AND THE PHARMACY FOUNDATION OF NORTH CAROLINA, INC.

Presented by Tom S. Miya, Ph.D.,
Dean, UNC-CH School of Pharmacy; Secretary, Pharmacy Foundation of NC, Inc.

It is both a pleasure and a privilege to present this report to this, the 109th Convention of the North Carolina Pharmaceutical Association. As I reviewed my past reports to this Convention, I noticed that each year has been a year of extraordinary accomplishments. This year is no different. This is the year of the students, a year in which the students "got it all together." The hallmark of student activities has been greater involvement in campus and regional service.

Supported by the Pharmacy Student Senate and 165 student volunteers, the students took national honors for their outstanding efforts to educate students and the community about AIDS. The Assistant Secretary for Health Award on AIDS Awareness was won in competition with all accredited schools of pharmacy and beat out second-place winner, the University of Kentucky, and third-place winner, the University of California, San Francisco. Among the many students, lead roles were played by Cori Hefter (5th-year student from Cary), Dana Kiser (4th-year student from Cherryville), and Joseph Abdallah (5th-year student from Smithfield). Secretary Robert Windam suggested that the UNC project "should be a model for every college and university in the country." The students received a commendation certificate and $2,500 for the student scholarship fund. The Burroughs Wellcome Company graciously supported the project.

Among many other activities, the Academy of Students of Pharmacy anti-drug abuse program, headed by Kim Adams (5th-year student from Andrews) is notable in content and scope. The program reached 12 of the 42 elementary schools that requested the program and about 1,400 students were contacted. Some of you attended the highly successful Parents' Day sponsored by the student body. The event, chaired by Eleni Zourgoukis (4th-year student from Asheville), was attended by over 400 parents.

In curricular matters, we continue attempting to keep pace with rapidly changing external forces. A major activity is the incorporation of materials relevant to biotechnology. A faculty development workshop was held to address this issue. Our second-to-none Area Health Education Centers Program, their faculty as well as our volunteer practitioner-instructors continue the tremendous work in behalf of our students. Director Steve Caiola, together with Bob Schollard, June McDermott and Bob Smith play key roles.

The research and service activities of the faculty continue unabated. A coup this year was the grant funded by the Hartford Foundation to Dr. Abraham Hartzema in the amount of $565,000 to study medication-prescribing habits and drug-use patterns in rest homes. This comprehensive and multidisciplinary research should give insight into how services in rest homes can be improved and made more cost-efficient. The Molecular Modeling Laboratory will host the American Chemical Society's workshop this summer. This program is expected to give this premier laboratory even more national and international exposure. The Division of Medicinal Chemistry, headed by Dr. Claude Piantadosi, has been nationally prominent in their research activities. For a group its size involved in teaching, service and research, it is incredible that 18 invention disclosures have been made in as many months. Several of these have been patented and receiving close scrutiny from both the federal and private sectors. The Division of Medicinal Chemistry and Natural Products, of which the Natural Products Laboratory, Molecular Modeling Laboratory, and the Radiosynthesis Laboratory are a part, received a special Dean's Commendation for their dedication and accomplishments during the School's Award Night ceremonies.

Our undergraduate applicant pool continues to be excellent with well-qualified applicants exceeding available slots by a margin of 2 to 1. Actual applications far exceed this margin. The entering class (Fall 1988) showed the first upswing of male enrollment in many years—40%, women at 60%. Currently women constitute approximately 68% of the student body of 525 in the 3 years of the B.S. program. The quality of our students is exemplified by the presence of 20 high school valedictorians in the entering class.

Continuing Education, under the able direction of Dr. Betty Dennis, continues to flourish. During the last fiscal year 500 hours of CE programs were provided. Cooperation with local,

state and national organizations and assistance from industry have enabled us to provide affordable and high-quality programs. The UNC CE program was complimented for its quality and received full 6-year provider accreditation.

There are many things that will need to go unreported, but an item I do not want to forget is to express appreciation to all of you for the support you have given in time and substance which make our work towards better North Carolina Pharmacy possible. Special appreciation goes to Associate Dean George Cocolas and Associate Dean for Academic Program Development, A. Wayne Pittman, for the special roles they play as administrators and teachers.

Our greatest need now is space. Planning for the STAR (Support for Teaching and Research) Wing is still in its early stages. Matching funds of at least $5 million are being sought from various sectors. It will be an onerous task.

PHARMACY FOUNDATION OF NORTH CAROLINA, INC.

The Pharmacy Foundation of North Carolina does an excellent job of meeting its objective of supplying resources to the UNC School of Pharmacy to meet its mission. President Ralph Rogers provides the leadership and together with the 24-member Board offers advice.

Table I shows current Directors and their terms of service as well as officers, and Executive and Investment Committee members. Notable action was the conferring of life-time honorary Directorship to Howard and Mescal Ferguson.

Continued on page 37

Table I

Directors

Paul B. Bissette, Jr. (1992)	Sara J. Hackney (1990)	Joseph P. Tunstall (1989)
Charles D. Blanton, Jr. (1990)	John C. Hood (1989)	Mitchell W. Watts (1992)
Edward A. Brecht (1991)	Pamela U. Joyner (1990)	W. Artemus West (1990)
Tom R. Burgiss (1989)	Banks D. Kerr (1991)	Lloyd M. Whaley (1989)
Laura G. Burnham (1989)	W. Whitaker Moose (1990)	Josiah R. Whitehead (1992)
James L. Creech (1992)	Ernest J. Rabil (1989)	William H. Wilson (1992)
Harold V. Day (1991)	Ralph P. Rogers, Jr. (1991)	Barney Paul Woodard (1992)
William H. Edmondson (1990)	W. J. Smith (1991)	Frank F. Yarborough (1991)

Honorary Directors

Howard Q. Ferguson — Mescal Ferguson

Officers

President—Ralph P. Rogers, Jr. — Vice President—E. A. Brecht — Secretary—Tom S. Miya

Executive Committee

E. A. Brecht	H. Q. Ferguson	W. W. Moose
H. V. Day	T. S. Miya	R. P. Rogers

Investment Committee

E. A. Brecht	W. H. Edmondson	T. S. Miya
T. R. Burgiss	B. D. Kerr	R. P. Rogers

Ex officio Member

A. H. Mebane, Exec. Director, NCPhA

Auditor

Blackman & Sloop, PA

REPORT OF THE ACADEMY OF STUDENTS OF PHARMACY (ASP) OF THE APhA, UNC-CH School of Pharmacy

presented by Amy Greeson, President

UNC's ASP membership continues to grow in numbers and in strength. Throughout the year our chapter has been involved in the following projects and activities: diabetes, cholesterol and hypertension screening clinics; ASP and Drug Abuse T-shirt sales; two issues of our student publication, *Pharm Phacs*; Handbook of Nonprescription Drug Index sales; membership packets for our 1989 Drive; a pre-Pharmacy Club for undergraduates pursuing a career in pharmacy; one annual Patient Counseling Competition; the first of hopefully many campus-wide health fairs; increasing participation and support of our Drug Abuse Program; and more than twenty students to attend each of the regional and national conventions.

ASP held several meetings throughout the 1988-89 school year which included presentations by Mike Zatepak and Steve Russell of Eli Lilly on "Careers In Industry"; by Eve Taylor on "Stress and Time Management"; by Dr. Tim Ives on "Substance Abuse"; and by our own Al Mebane on "Make Patient Counseling Work For You: 101 Ways to Meet Your Mate."

Perhaps one of the most successful projects of the year involved approximately 60 students working together on our Drug Abuse Prevention Program. The program began with a couple of skits in which the students became involved in hypothetical situations. The scenarios usually included a party scene, an athletic event, or a slumber party. Afterwards, the skit was discussed and we tried to answer any questions that the students may have.

It is frightening and amazing to realize how much these elementary school children know about drugs and to hear of their personal confrontations with drugs. For example, several 4th graders have asked, "What if you've seen your parents do drugs?" Another 4th grader asked, "How many joints does it take before it will really hurt you?"

Truly, our Drug Abuse Prevention Program has been wonderfully rewarding and it has been a major learning experience. In addition, because of the positive feedback from the students we know that our program has been a success. We believe in our fight against drug abuse and we will continue in our quest to reach elementary school children and make a permanent impact on their lives.

This year, ASP has also provided diabetes, cholesterol, and hypertension screening clinics for UNC students and faculty, for parents on Parent's Day, for undergraduates on our Health Fair day, for shoppers at Kroger's, and for our alumni on two Alumni Days.

In December, we delivered toys to the Lenox Children's Rehabilitation Center in Durham. Those of us who toured the facility were quickly reminded that pharmacists don't merely belong behind the counter—that is, the reason most of us pursued this profession was to be able to reach out and to help others. It is our hope that ASP will become more involved with the Center next semester.

Our fund raisers (including selling the Handbook of Nonprescription Drug Indexes and T-shirts) helped 22 students attend the 1989 APhA Annual Meeting in Anaheim, California this past April. Anaheim brought several "firsts" to our chapter, including the first time we had one of our members serve as a regional delegate, the first time we displayed our chapter's activities (as well as the school's AIDS exhibit that recently received a national award), and it was the first time that most of us felt the earth literally move under our feet as we experienced a real earthquake during our visit.

A big event for our chapter this past semester was organizing UNC's first Campus-Wide Health Fair. This was set-up at a central location for all undergraduates in hopes of providing them with information on all the health careers offered by UNC. The School of Pharmacy was joined by the Schools of Medicine, Dentistry, Nursing and other Allied Health Professions.

ASP activities planned for next semester include our Health Fair; distributing our membership packets which will contain pens, notepads, coffee mugs, etc. donated by several drug manufacturers; and hosting our annual back-to-school picnic at the Storybrook Farm; and perhaps, we may begin our first Hospice student branch.

We are constantly learning and growing—and aiming towards becoming the pharmacists that we know we can become. UNC takes pride in its activities and its accomplishments. We are determined to make a positive impact on our

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RITE OF THE ROSES 1989

Each year, the NCPhA pauses to recall those members who have died since the last annual meeting. At the first session of the convention, the names were read and a red rose was displayed in a vase for each deceased member. Third Vice-President, Robert Worley and his wife, Mary Lou, conducted the ceremony. Those remembered this year are:

C. W. BYNUM
New Bern

RAYMOND L. CREEKMORE
Reiglewood

ROBERT L. IRWIN
Elkin

ARTHUR G. KISER
Asheville

FOSTER J. SIMMONS
Conover

ROBERT B. COX
Wallburg

FRED FIGLEAF
Newberry, FL

A. R. JOHNSON
Winston-Salem

ROY B. RABB
Marion

QUAY H. BECK
Skyland

HARRY C. TEE, JR.
Wilson

PAUL LEWIS FISHER
Elkin

THREE FRIENDS OF MINE

When I remember them, those friends of mine,
Who are no longer here, the noble three,
Who half my life were more than friends to me,
And whose discourse was like a generous wine,
I most of all remember the divine Something,
that shone in them, and made us see
The archetypal man, and what might be
The amplitude of Nature's first design.
In vain I stretch my hands to clasp their hands;
I cannot find them. Nothing now is left
But a majestic memory. They meanwhile
Wander together in Elysian lands,
Perchance remembering me, who am bereft
of their dear presence, and remembering, smile.

Henry Wadsworth Longfellow

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the willingness to invest in people is the key to leadership.

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Our conviction that a company can only be as successful as the people who give it life has never been stronger. With people who take pride in their individual abilities and common purpose, Glaxo is growing faster than any major prescription pharmaceutical company in the country.

To sustain that momentum, we work hard at providing programs that help our people build on their strengths, tackle new responsibilities and grow into new positions. And we keep the lines of communication open with programs that encourage speaking out. That's because we also believe growing rapidly should never mean growing apart. At Glaxo, there is a feeling of high spirit and energy that stems from people expecting the best from each other and from their company. We invite you to share it.

We currently have the following part-time positions available at our Corporate Headquarters facility located in Research Triangle Park, N.C.

TELEMARKETING ASSOCIATES

These exciting positions within our Marketing and Sales Services Department will provide direct telephone sales support by contacting designated physicians and accounts to promote Glaxo products. Individuals will gather and consolidate information needed to complete reports requested by the Telepromotions Manager and maintain established records and computer logs to ensure prompt and efficient handling of new business and the servicing of existing business.

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Candidates interested in these positions, may send your resume to: **Human Resources Department, Job # 5370B902, Glaxo Inc., P.O. Box 13398, Research Triangle Park, N.C. 27709.** (No phone calls or private agency referrals, please) An Equal Opportunity Employer M/F/H/V

Glaxo Inc.

Our belief begins with you

Welcome, New Members!

John B. Zatti, Durham
John W. Allen, Highalnds
Al Curry, Ormond Beach, FL
Ava Reynolds Haines, Raleigh
Timothy J. Ives, Efland
Billy Wayne King, II, Rocky Mount
Michael B. List, Raleigh
Arthur J. McBay, Chapel Hill
Waverly Lee Miller, Lexington
Barbara A. Norris, Mt. Olive
Gregory B. West, Cary
Joe R. Barnette, Jr., Jacksonville
Bryan Keith Bray, High Point
Philip B. Cates, Jr., Charlotte
Pamela Ann Corrigan, High Point
Cindy Crisp, Greensboro
Richard E. Crocker, Farmville
Gina Dickerson, Hamptonville
Carol Dixon, Fayetteville
Mac Fairly, Greensboro
Gene Glaze, Chapel Hill
Anita M. Hobbs, Conover
Mary Page Lynn, Raleigh
Mark Steven McCauley, Greensboro
Shelly Smith Millard, Durham
Steve Moss, Raleigh
Kim Newkirk, Carrboro
John W. Roten, Jr., Lake Wylie, SC
Roy Seufert, Carrboro
Amy Slater, Raleigh
Jenni Smart, Greenville
Laura Williams, Charlotte
Howard C. Gaines, Jr., Charlotte
Al DePorter, Fayetteville
Ronald L. Hargis, Jr., Burlington
Mark T. Haltom, Thomasville
Vince Stevens, Chapel Hill
Angela Bray, Charlotte
Beth Brown, Winston-Salem
Matthew C. Carterette, Chadbourn
Jeff Collins, Horse Shoe
Jill Davies, Chapel Hill
Lynne Karen Kearns, Chapel Hill
Wendy Langley, Burlington
Lucy Bly Lofland, Newton
Tammy L.Markham, Charlotte
Kimberly M. Owen, Carrboro
Robbin Robertson, Greensboro
James Robertson, Hope Mills
James Nathaniel Watkins, Jr., Chapel Hill

PharmaDates

1989

August 4-6—Southeastern Officers' Conference, Williamsburg, VA

August 14—Board of Pharmacy Reciprocity Examination, Institute of Pharmacy

August 15—Board of Pharmacy Meeting, Board of Pharmacy

August 22—NCPhA Public & Professional Relations Committee, Institute of Pharmacy

September 10—NCPhA Executive Committee Meeting, Institute of Pharmacy

September 18—Board of Pharmacy Reciprocity Examination, Institute of Pharmacy

September 19—Board of Pharmacy Meeting, Board of Pharmacy

September 20-21—NCSHP Fall Seminar, Greensboro

September 24—NCPhA Pharmacy Practice Seminar, Wilmington

October 8-14—NC PHARMACY WEEK

October 11-15—Pharmacy in the 21st Century, Williamsburg, VA

October 16—Board of Pharmacy Reciprocity Examination, Institute of Pharmacy

October 17—Board of Pharmacy Meeting, Board of Pharmacy

October 21—Endowment Fund Dinner, Kenan Center, Chapel Hill

November 11-15—NARD Annual Convention, San Antonio, TX

November 20—Board of Pharmacy Reciprocity Examination, Institute of Pharmacy

November 21—Board of Pharmacy Meeting, Board of Pharmacy

December 3-7—ASHP Midyear Clinical Meeting, Atlanta, Georgia

1990

March 10-14—APhA Annual Convention, Washington, D.C.

March 22—Socio-Economic Seminar, High Point

March 16-20—NCPhA Annual Convention, Durham

June 2-6—ASHP Annual Meeting, San Diego, CA

October 20-25—NARD Annual Meeting, Nashville, TN

EXHIBIT PROGRAM

Support these companies who have helped make the 1989 Convention a meaningful educational experience through the Exhibit Program. They have spent time and money to bring their representatives to Myrtle Beach to display and educate you.

All American Computers & Systems, Inc.
Allens & Hansburys, Division of Glaxo, Inc.
American Therapeutics Inc.
Amfac Health Care, MWC, Inc.
Bergen Brunswig Drug Co.
Boehringer Mannheim Diagnostics
Bristol Laboratories
Burroughs Wellcome Co.
Campbell University Drug Information Center
Carolina Medical Products Company
Compute-Rx
Drustar, Inc.
Eli Lilly and Company
Foxmeyer Drug Co.
General Computer Corporation
Geneva Generics, Inc.
Glaxo, Inc.
Goldline Laboratories
Health Con Services Inc.
Hoechst-Roussel Pharmaceuticals Inc.
Knoll Pharmaceuticals
Lakeside Pharmaceuticals
Liberty Drug Systems, Inc.
Marion Laboratories, Inc.
Merck Sharpe & Dohme
Merrell Dow Pharmaceuticals
Miles Inc., Diagnostics Division
North Carolina Pharmaceutical Association
North Carolina Society of Hospital Pharmacists
PharmaSTAT, Inc.
Publicom
Purepac Pharmaceutical Co.
QS-1 Pharmacy Systems
Qualex—Colorcraft
Renlar Systems, Inc.
Rugby Laboratories, Inc.
Sandoz Pharmaceuticals
Spear Associates, Inc.
Squibb/Vita-Stat
Store Fixtures & Planning, Inc.
The Boots Co. (USA) Inc.
The Upjohn Company
United Research Laboratories
VIP Computer Systems/Dr. TC Smith Co.
Wyeth-Ayerst Laboratories

GOLF TOURNAMENT

Thanks to those companies and individuals who sponsored the traditional golf and tennis tournaments:

Junior Little of Owens-Brockway and Mike Joyner of Dr. T.C. Smith Co./W.H. King Drug, Co-Chairmen

Green Fees by ***Glaxo, Inc.***
Cart Fees by ***Burroughs Wellcome Co.***
Refreshments by ***Owens-Brockway, Dr. T.C. Smith Co. and Justice Drug Division***

JEFFERSON-PILOT TENNIS TOURNAMENT

Sam Stuart of Jefferson-Pilot, Chairman
Sponsored by Jefferson-Pilot Insurance Company

SPECIAL THANKS AND APPRECIATION

The following companies have contributed to the educational programming of our Convention and sponsored speakers or events. We encourage you to thank their representatives whenever the opportunity arises.

Abbott Laboratories
Alco Health Services Corporation
American Heart Association
Dr. T.C. Smith Co.
Burroughs Wellcome Co.
Geer Drug
Geigy Pharmaceuticals
Glaxo, Inc.
Hoffman-LaRoche
Jefferson Pilot Insurance Co.
Justice Drug Division
Lederle Laboratories
Marion Laboratories
Merrell Dow Pharmaceuticals
NC Mutual Wholesale Drug Co.
Ortho Pharmaceutical Corp.
Owens-Brockway
Parke-Davis
Pfizer Pharmaceuticals
Smith Kline & French Laboratories
Traveling Members' Auxiliary

In addition to the companies listed above, the following companies supplied gifts and door prizes so you wouldn't go home empty handed.

Almay, Inc.
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Belk, Four Seasons, Greensboro
Belk, Myrtle Square Mall, Myrtle Beach
Burroughs Wellcome Company
Carolina Pottery
Dermik Laboratories, Inc.
Doak Pharmacal Co., Inc.
Dr. T.C. Smith Company
Duplin Wine Cellars
DuPont Pharmaceuticals
Fieldcrest
Geer Drug Company
Glaxo, Inc.
Glen Raven Mills Inc.
Hardee's
Hoechst-Roussel Pharmaceuticals, Inc.
Jack Eckerd Corporation
Johnson & Johnson
Justice Drug Company
Kendall Drug Company
Kerr Drug Stores
Lenox China
Marion Laboratories, Inc.
Mast Drug Co. Inc.
McKesson Drug Company
McNeil Pharmaceuticals
Merrell Dow Pharmaceuticals
N.C. Mutual Wholesale Drug Co.
Owens-Brockway Prescription Products
Peoples Drug Store Inc.
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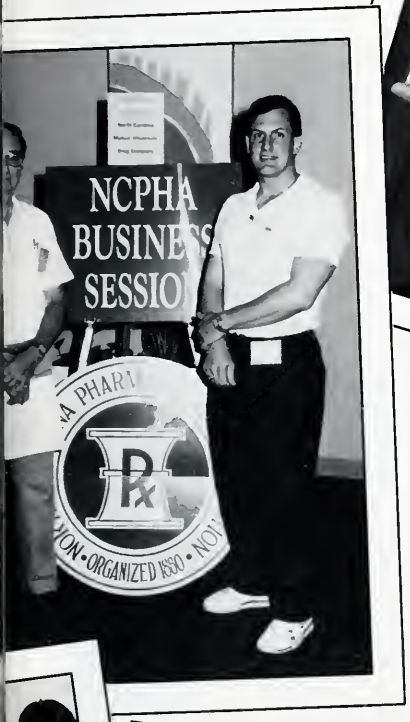
Pippin Enterprises
Riker 3M, 3M Health Care Group
Rite Aid Corporation
Rugby Laboratories
Sandoz Pharmaceuticals Corp.
Schering Corp.
Scott Drug Company
Smith Wholesale Drug Company
Southern Living
Syntex Laboratories, Inc.
Wal-Mart Pharmacy
W. H. King Drug
Whitman's Chocolates
Westwood Pharmaceuticals Inc.
Wyeth-Ayerst Laboratories

Convention Pictorial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AXID®
nizatidine

Enhances compliance and convenience

Patients appreciate Axid, 300 mg, in the Convenience Pak

In a Convenience Pak survey (N = 100)[1]

- *100% said the directions on the Convenience Pak were clear and easy to understand*
- *93% reported not missing any doses*

Pharmacists save time– at no extra cost

- *The Convenience Pak saves dispensing time and minimizes handling*

The Convenience Pak promotes patient counseling

- *Pharmacists dispensing the Axid Convenience Pak can encourage compliance and continued customer satisfaction*

Convenience Pak is available at no extra cost

Lilly

Eli Lilly and Company
Indianapolis, Indiana
46285

1. Data on file, Lilly Research Laboratories

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AXID®

nizatidine capsules

Brief Summary

Consult the package literature for complete information.

Indications and Usage: Axid is indicated for up to eight weeks for the treatment of active duodenal ulcer. In most patients, the ulcer will heal within four weeks.

Axid is indicated for maintenance therapy for duodenal ulcer patients at a reduced dosage of 150 mg h.s. after healing of an active duodenal ulcer. The consequences of continuous therapy with Axid for longer than one year are not known.

Contraindication: Axid is contraindicated in patients with known hypersensitivity to the drug and should be used with caution in patients with hypersensitivity to other H_2-receptor antagonists.

Precautions: *General* — 1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Because nizatidine is excreted primarily by the kidney, dosage should be reduced in patients with moderate to severe renal insufficiency.

3. Pharmacokinetic studies in patients with hepatorenal syndrome have not been done. Part of the dose of nizatidine is metabolized in the liver. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests — False-positive tests for urobilinogen with Multistix® may occur during therapy with nizatidine.

Drug Interactions — No interactions have been observed between Axid and theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450-linked drug-metabolizing enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increases in serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility — A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice; although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a two-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy — Teratogenic Effects — Pregnancy Category C — Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus and at 50 mg/kg it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers — Studies conducted in lactating women have shown that < 0.1% of the administered oral dose of nizatidine is secreted in human milk in proportion to plasma concentrations. Caution should be exercised when administering nizatidine to a nursing mother.

Pediatric Use — Safety and effectiveness in children have not been established.

Use in Elderly Patients — Ulcer healing rates in elderly patients are similar to those in younger age groups. The incidence rates of adverse events and laboratory test abnormalities are also similar to those seen in other age groups. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of nizatidine included almost 5,000 patients given nizatidine in studies of varying durations. Domestic placebo-controlled trials included over 1,900 patients given nizatidine and over 1,300 given placebo. Among reported adverse events in the domestic placebo-controlled trials, sweating (1% vs 0.2%), urticaria (0.5% vs < 0.01%), and somnolence (2.4% vs 1.3%) were significantly more common in the nizatidine group. A variety of less common events was also reported; it was not possible to determine whether these were caused by nizatidine.

Hepatic — Hepatocellular injury, evidenced by elevated liver enzyme tests (SGOT [AST], SGPT [ALT], or alkaline phosphatase), occurred in some patients and was possibly or probably related to nizatidine. In some cases, there was marked elevation of SGOT, SGPT enzymes (greater than 500 IU/L) and, in a single instance, SGPT was greater than 2,000 IU/L. The overall rate of occurrences of elevated liver enzymes and elevations to three times the upper limit of normal, however, did not significantly differ from the rate of liver enzyme abnormalities in placebo-treated patients. All abnormalities were reversible after discontinuation of Axid.

Cardiovascular — In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

CNS — Rare cases of reversible mental confusion have been reported.

Endocrine — Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to Axid. Impotence and decreased libido were reported with equal frequency by patients who received Axid and by those given placebo. Rare reports of gynecomastia occurred.

Hematologic — Fatal thrombocytopenia was reported in a patient who was treated with Axid and another H_2-receptor antagonist. On previous occasions, this patient had experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental — Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity — As with other H_2-receptor antagonists, rare cases of anaphylaxis following administration of nizatidine have been reported. Because cross-sensitivity in this class of compounds has been observed, H_2-receptor antagonists should not be administered to individuals with a history of previous hypersensitivity to these agents. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other — Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine administration have been reported.

Overdosage: Overdoses of Axid have been reported rarely. The following is provided to serve as a guide should such an overdose be encountered.

Signs and Symptoms — There is little clinical experience with overdosage of Axid in humans. Test animals that received large doses of nizatidine have exhibited cholinergic-type effects, including lacrimation, salivation, emesis, miosis, and diarrhea. Single oral doses of 800 mg/kg in dogs and of 1,200 mg/kg in monkeys were not lethal. Intravenous median lethal doses in the rat and mouse were 301 mg/kg and 232 mg/kg respectively.

Treatment — To obtain up-to-date information about the treatment of overdose, a good resource is your certified regional Poison Control Center. Telephone numbers of certified poison control centers are listed in the *Physicians' Desk Reference (PDR)*. In managing overdosage, consider the possibility of multiple drug overdoses, interaction among drugs, and unusual drug kinetics in your patient.

If overdosage occurs, use of activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance.

PV 2096 AMP [013089]

Eli Lilly and Company
Indianapolis, Indiana
46285

Additional information available to the profession on request.

Axid® (nizatidine, Lilly)

Axid® (nizatidine, Lilly)

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WOMAN'S AUXILIARY 1989 CONVENTION MEMORIES

A Warm Welcome at the First Business Session (l-r) Kay Rhoades, Jewell Oxendine, Frances Jones, Ginger Lockamy, Jean Morse, Nancy Johnson, Yvonne Brown, Lib Fearing.

Walk-A-Thon Walkers (l-r) Daphne Ashworth, Maxine West, Suzan Maddox, Jean Paul Gagnon, Erie Cocolas, Ann Gagnon.

1989-90 Officers (l-r) Suzanne Bizell, Rose Boyd, Eloise Watts, Jewell Oxendine, Frances Jones, Rebecca Work, Carolyn O'Quinn, Betsy Mebane, Lou Worley, Suzan Maddox.

HIGHLIGHTS OF THE 1989 WOMAN'S AUXILIARY CONVENTION

North Myrtle Beach, S.C.

OPENING DAY

The 62nd Annual Convention of the Woman's Auxiliary of the North Carolina Pharmaceutical Association met May 17-21, 1989 at the Myrtle Beach Hilton in sunny South Carolina. The beach was beautiful and it was just wonderful to see old friends again and to make new friends. When we arrived Wednesday afternoon, I could hear the steel band playing outside by the pool, and I was filled with excitement. At the registration desk everyone received a "goody bag" with many useful items in it from Geer Drug Company. Soon we were settled in our lovely room with a balcony overlooking the beautiful blue ocean.

At 6:00 p.m. everyone gathered in the lobby for a reception, prior to the Opening Session Banquet, in honor of the presidents of the NCPhA, Woman's Auxiliary and T.M.A. The highlight of the banquet was our featured speaker, Robert H. Henry, one of America's busiest and most charismatic speakers.

BEACH WALK-A-THON

Woman's Auxiliary Convention activities got into full swing early Thursday morning with the 7:00 a.m. Beach Walk-A-Thon. Many thanks to Mrs. William V. O'Quinn, Chairman of the Ways and Means Committee, and the members of her committee—Mrs. Robert Worley, Mrs. Julian Upchurch, Mrs. David Moody, and Mrs. Sara Ann Sasser—who assisted her in planning the Walk-A-Thon. Through our walkers and our generous contributors, we raised over $2,000. A special thanks to Kendall Drug Company who donated T-shirts for Walk-A-Thon participants. The three medal winners were:

Gold	Mrs. Ronald Maddox, Lillington
Silver	Mr. Jay Massey, Durham
Bronze	Mrs. Allan Boyd, Kenly

FASHION SHOW

After stopping for coffee at the Hilton's Alfredo's Restaurant and getting dressed again, it was time for the brunch and fashion show on the South Deck. The lovely ladies of Victoria's Ragpatch of Myrtle Beach, Ocean Isle, and Calabash modeled the latest fashions for most any occasion. Mrs. Ronald Maddox gave the invocation before brunch. Our thanks to Glaxo, Inc. for this nice brunch. Thank you Mrs. George Cocolas and Mrs. Al Mebane III for the attractive table decorations.

OTHER FUN ACTIVITIES

After the brunch we hurried to get on the bus to go on the "Shopping Spree" to Pawley's Island.

Thursday evening the Traveling Member's Auxiliary sponsored a dance featuring "The Embers." As usual, it was one of the highlights of the convention. We are grateful to the T.M.A. for this fun-filled evening.

Friday morning the Woman's Auxiliary activities began with a coffee hour in the Hospitality Room. Sausage and biscuits and cinnamon buns were provided by Hardee's. Friday evening concluded at 11:00 p.m. with a late-night get together flavored with an ice cream buffet and desserts galore.

Saturday evening there was a luau feast along with the Hawaiian entertainment group, "Lei Aloha's Polynesian Rainbow Revue." They performed traditional dances and lured some the audience on stage for a hula lesson. It was certainly a fun evening and such a nice climax to a great convention.

BUSINESS SESSION

On Friday the Woman's Auxiliary's 62nd Annual Business Session began at 9:30 a.m. There were 51 members present. Mrs. Jesse Oxendine gave an inspirational invocation which was taken from Anne Morrow Lindbergh's book, *Gift From The Sea.* Mrs. Keith Fearing extended a welcome to the convention. NCPhA President, Al Lockamy, and T.M.A. President, Tom Terry, brought greetings to us from their respective organizations. Mrs. Henry H. Shigley presented the "Rite of the Roses" for our members who died during the past year. We are grateful to the many wholesalers, pharmacists, companies, and individuals who donated the many nice door prizes that were awarded at the close of the business session. Thanks for the assistance for our Pages, Mrs. W. H. Wilson, Mrs. Robert Worley, and Mrs. Larry Brown.

AUXILIARY REPORTS

I am happy to report that $300 was given to Mission Air, our state service project. The

Continued on page 26

WOMAN'S AUXILIARY REPORT

Continued from page 25

Charlotte Auxiliary also gave $300 to Mission Air. The Vial of Life (VOL) Service Project continues to receive requests from all over the state for the VOL slide presentation and supplies. The Auxiliary's membership is 186.

PAST PRESIDENTS' BREAKFAST

Saturday morning there was a past presidents breakfast. Each past president told some of the highlights of her term as president. Mrs. J. C. Jackson, who served as president in 1944-46, was the earliest president to attend.

INSTALLATION OF OFFICERS LUNCHEON

At 12:00 noon a delicious luncheon sponsored by Burroughs Wellcome was served in "Another World" on the top floor of the Hilton. Mrs. Shelton Boyd gave the invocation. We were entertained by "The First Resort," a sweet adelines barbershop quartet. All past presidents in attendance were recognized. Officers for 1989-90 were installed by Mrs. Lamar Morse. Each officer received a lovely rose. The president's gavel then changed hands to our new president, Mrs. A. H. Mebane III. We can look forward to a successful year for the Auxiliary under her capable leadership. Mrs. Mebane also provided the lovely luncheon decorations. My thanks to each of you for the beautiful silver tray which was presented to me in recognition of my term as your president.

MANY THANKS

Thanks to my Executive Board for all their support, inspiration and love and to the committee members who did their jobs so well. A special thanks to Erie Cocolas and Betsy Mebane for the super job they did making the arrangements for the Auxiliary events during the convention.

Thank you for the honor of serving as your president for 1988-89. Each of you are very special and dear to me.

Love to all,
Rose Boyd
President, Woman's Auxiliary, NCPhA

WOMAN'S AUXILIARY 1989-90

Officers

Mrs. Alfred H. Mebane III (Betsy), Chapel Hill
President

Mrs. Robert W. Worley (Mary Lou), Princeton
First Vice President

Mrs. Charles F. Jones Jr. (Frances), Oxford
Second Vice President

Mrs. Ronald W. Maddox (Suzan), Lillington
Recording Secretary

Mrs. William V. O'Quinn (Carolyn), Durham
Corresponding Secretary

Mrs. Jack G. Watts (Eloise), Burlington
Treasurer

Mrs. David R. Work (Rebecca), Chapel Hill
Parliamentarian

Mrs. W. Robert Bizell (Suzanne), Kinston
Historian

Mrs. Alan C. Boyd (Rose), Kenly
Advisor

Mrs. Leslie H. Davis (Mary Lou), Charlotte
Advisor

Mrs. Jesse E. Oxendine (Jewell), Charlotte
Acting State Coordinator

Committee Chairpersons

Mrs. Shelton B. Boyd (Margaret), Mt. Olive
Nominations

Mrs. David S. Moody Jr. (Diane), Durham
Ways & Means

Mrs. Benjamin T. Brinson (Leveita), Chocowinity
Resolutions

Mrs. Charles T. Jones Jr. (Frances), Oxford
Membership

Mrs. Robert W. Worley (Mary Lou), Princeton
Hospitality

Mrs. George H. Cocolas (Erie), Chapel Hill
Publications

Mrs. W. Whitaker Moose (Dot), Mt. Pleasant
Necrology

75th ANNUAL MEETING OF T.M.A.

NORTH MYRTLE BEACH HILTON
MYRTLE BEACH, SOUTH CAROLINA
May 19, 1989

Meeting called to order by President, Tom Terry, III. The invocation by C. Rush (Rusty) Hamrick, III.

GREETINGS

Al F. Lockamy, Jr. President of NCPhA brings greetings from NCPhA. He thanked us for our support and contribution to Pharmacy. He asked that we continue our help and support to the pharmacists of North Carolina.

RITE OF ROSES

The Rite of Roses was conducted by C. Rush Hamrick and Zack Lyon in memory of E. E. Merchant, Jr., retired from Abbott Labs. All observed a moment of silence after the ceremony.

MINUTES

The President stated that the mintues had been read and approved by the board and officers and asked that they be omitted. On a motion by Warren Spears and 2nd by Dick Hoffman, the motion passed.

TREASURER REPORT BY MAC McCOMBS

Expenses for 1988 were $2,881.02; Savings $2,530.53; C.D. Note $2,500.00; Checking $1,582.34 . . . a total of $6,612.87 Cash on Hand. At this time the Audit Committee of Bill Andrews and Zack Lyon stated that the books were in order. On a motion by Roland Thomas and 2nd by Doug Sanders, that the report be accepted as presented. Passed.

T.M.A. FOUNDATION REPORT BY C. RUSH HAMRICK

Total cash on hand $17,226.69. Mr. Hamrick asked for donations from any source and send same to C. Rush Hamrick, Box 1806, Shelby, N.C. 28150.

OLD BUSINESS

None

NEW BUSINESS

On a discussion of how to get new members. This was discussed by Doug Sanders–Jim Parker–Warren Spears–suggested a regional golf tournament to earn money. No decision was made. The President appointed a committee to suggest or formulate a way to raise money. The committee as follows: Doug Sanders, Chairman; Warren Spears and Bruce W. Lipton. A later discussion suggested that Mac McCombs be added to the Committee. All agreed.

NEW MEMBERS

Three new members were present.

Life Members list was presented:

E. E. Merchant, Jr. (Abbott Labs)
James E. Holloway (Parke Davis)
N. E. Hood, Jr. (Parke Davis)
John W. Canipe (Kendall Drug)
Charles L. Kimball (W. H. King Drug)

A motion, that the above be accepted as Life Members, was made by Warren Spears; seconded by Zack Lyon. Passed.

TENNIS

Sam P. Stuart CLU. Sam reported that 23 played tennis.

GOLF

By Junior Little — Junior reported that 92 played golf. He also stated that Owens-Brockway would sponsor golf next year. The T.M.A. is greatful for the support of the following:

Co-Chairman Junior Little (Owens Brockway) and Mike Joyner (W. H. King Drug)
Green Fees paid by Glaxo, Inc.
Cart Fees paid by Burroughs Wellcome Co.
Refreshment & Lunch courtesy of Owens Brockway, Dr. T.C. Smith Drug, and Justice Drug Company.
Many-Many thanks to the sponsors!

ENTERTAINMENT REPORT BY DICK HOFFMAN

Some good reports, but there were more reports against the entertainment than for it.

REPORT OF NOMINATING COMMITTEE

Bobby McDaniel stated the Committee recommended the following officers for 1989-90:

President . . . . . Rudy Snow (Mayrand, Inc.)
1st V. Pres. . . . . Dick Hoffman (Dr. T. C. Smith Co.)
2nd V. Pres. . . . . Junior Little (Owens Brockway)
Sec.-Treas. . . . . L. M. McCombs (Eli Lilly & Co. [Retired])

On a motion by Zack Lyon and 2nd by Rusty Hamrick that the slate of officers be accepted and that the nominations be closed. Passed. All were elected as presented.

Continued on page 37

Incoming T.M.A. President, Rudy Snow, Mayrand, Inc. (r) presents the Past President's Plaque to outgoing T.M.A. President, Tom Terry, Owens-Minor, Inc. (l).

1989-90 T.M.A. Officers: (l-r) Rudy Snow, Mayrand, Inc., President, Dick Hoffman, Dr. T.C. Smith Company, First Vice President; Junior Little, Owens-Brockway, Second Vice President; L.M. McCombs, Eli Lilly & Company (retired), Secretary-Treasurer.

MEETING OF THE T.M.A. OFFICERS AND BOARD OF DIRECTORS

All enjoyed a breakfast of orange juice, coffee, eggs, bacon, grits, and biscuits.

Meeting called to order by T.M.A. President, Tom Terry, III.

PRESENT

Tom Terry, Bobby McDaniel, Doug Sanders, C. Rush Hamrick, Rusty Hamrick, Roy Moss, Rudy Snow, Frank Fife, Bill Andrews, Zack Lyon, Dick Hoffman, Mac McCombs.

MINUTES

Minutes were read by all present. On a motion by Frank Fife and 2nd by Doug Sanders, that the minutes be approved as presented. Passed.

TREASURY REPORT

Treasurer report was read. Expenses for year—$2881.02.

Savings	$2530.53
C.D. Note	2500.00
Checking	1582.24
TOTAL	$6612.87

Motion by Zack Lyon, 2nd by Roy Moss that treasury report be approved. Passed.

LIFE MEMBERS

Zack Lyon and Doug Sanders asked that we approve Charles L. Kimball for life member. On a motion by Zack Lyon and 2nd by Doug Sanders that we disregard a letter requesting Life Membership due to the fact that Mr. Kimball was paralized and could not write. Motion passed.

Four (4) letters asking for Life Membership in the T.M.A. were presented:

E. E. Merchant, Jr. ..... (Abbott Labs)
James L. Hollowday ..... (Parke Davis)
N. E. Hood, Jr. ..... (Parke Davis)
John W. Canipe ..... (Kendall Drug Co.)

On a motion by Zack Lyon and 2nd by Roy Moss that all be granted Life Membership. Passed.

OLD BUSINESS

I was requested to check with Al Mebane and see if he can meet with the officers and board the week before Thanksgiving. If so, I will set up a meeting in Greensboro.

NOMINATING REPORT

The report was not ready at this meeting.

NEW BUSINESS

See if we can get a list of manufacturers who travel the state to see if we can get some new members.

PUBLICITY

C. Rush Hamrick was asked to write a letter to NCPhA stating what the T.M.A. does for Pharmacy and see if we can get some publicity, which in turn will get us some new members.

There being no further business, a motion by McDaniel and 2nd by Doug Sanders that we adjourn. Passed.

L. M. McCombs
Secretary-Treasurer

TRAVELING MEMBER'S AUXILIARY 1989-1990

OFFICERS

Rudy Snow, Mayrand Inc.
President

Dick Hoffman, Dr. T.C. Smith Co.
First Vice President

Junior Little, Owens-Brockway
Second Vice President

L.M. McCombs, Eli Lilly & Co. (Retired)
Secretary-Treasurer
Box #7
Creedmoor, NC 27522
(919) 528-0494

BOARD OF DIRECTORS

Tom Tery III, Owens-Minor, Inc.
5 Years

Douglas Sanders, W.H. King Drug
4 Years

John T. Black (Emeritus), Colorcraft Corp.
3 Years

Frank Fife, Owens-Minor, Inc.
3 Years

Zack Lyon, W.H. King Drug (Retired)
2 Years

Roy M. Moss, CMR, A.H. Robins Co.
1 Year

MEETING OF T.M.A. FOUNDATION

PRESIDING

C. Rush Hamrick in absence of Chairman, Tom Sanders.

PRESENT

Tom Terry, Bobby McDaniel, Doug Sanders, C. Rush Hamrick, Rusty Hamrick, Roy Moss, Rudy Snow, Frank Fife, Bill Andrews, Zack Lyon, Dick Hoffman, Mac McCombs.

TREASURER REPORT

C. D. Note in Durham at CCB		$17,290.93
Income		4,435.75
Disbursements		2,500.00
U.N.C. Pharmacy Student Loan Fund	1,500.00	2,500.00
Campbell Phcy Student Loan Fund	1,000.00	

Net Worth 5/16/89

Cleve. Fed S&L Pass Book	$ 673.68
CCB C.D. Note	16,553.01
Total	$17,226.69

To date 5/18/89 . . . The Foundation Fund has sent $14,200.00 to NCPhA for Loan.

On a motion by Zack Lyon and 2nd by Bobby McDaniel that we transfer $1,000.00 from T.M.A. savings account to Foundation Fund and send $1,500.00 to the UNC School of Pharmacy and $1,000.00 to the Campbell University School of Pharmacy. McCombs objected because it would just about deplete his cash flow. Nevertheless, it passed.

BOOKS AUDIT

C. Rush Hamrick asked Zack Lyon and Bill Andrews if they would audit the T.M.A. and Foundation Fund books. Both agreed.

On a motion by C. Rush Hamrick and 2nd by Doug Sanders, that the directors and officers for the T.M.A. Foundation Fund remain the same except rotate the directors 1=3, 2=1, 3=2 years. Passed.

DIRECTORS

1 Year

Rush Hamrick, Jr.	Horace Lewis
Tom Sanders	Doug Sanders

2 Years

Bill Andrews	Len Phillipps
Frank Fife	Ralph Rogers, Jr.

3 Years

Zack Lyon	Bobby McDaniels
Tom Terry, III	Roy Moss

OFFICERS

Chairman ..... Tom Sanders
Sec.-Treas. ..... Rush Hamrick, Jr.
Asst. Sec.-Treas. ..... L. M. McCombs

All were asked to donate to the Foundation Fund:

Mac McCombs	$20.00	Cash
Frank Fife	40.00	Cash
Zack Lyon	20.00	C.K.
Rudy Snow	20.00	C.K.
Bill Andrews	20.00	Cash
Dick Hoffman	20.00	Check
Frank Milstead	20.00	Cash
Jack Watts	20.00	Check
Marion Suitt	20.00	Cash
W. V. O'Quinn	50.00	C.K.
R. T. White	20.00	C.K.

There being no further business, the meeting was adjourned.

L. M. McCombs
Asst. Sec.-Treasurer

NCPhA 1988-89 COMMITTEE REPORTS

REPORT OF THE NATIONAL LEGISLATIVE COMMITTEE

The committee convened at the Institute of Pharmacy on May 5, 1989. Present at the meeting were Jerry T. Gaylord, Whitaker Moose, Jerry Brunson, William Edmondson, Milton Skolaut, Joseph Whitehead, William Randall, Seymour Holt, and Jean Paul Gagnon, Chairman.

The Committee met for appoximately six hours to discuss the following topics:

1.) The Medicare Catastrophic Coverage Act of 1988
2.) Physician Dispensing
3.) Mail Order Programs

In addition, the committee discussed the Health Care Financing Administration's (HCFA's) earned discount program and the problems associated with faxing prescriptions.

Two members of the committee were assigned to present and lead the discussion on one of the above topics. Each topic was then discussed in depth by the committee.

The important points discussed with regard to the Medicare Catastrophic Health Bill were the Point of Sale (POS) electronic data system that will be installed in each pharmacy, the role of technicians, the role of counseling, drug utilization, review, Medicare/Medicaid crossovers, spouse impoverishment, and home health care provisions. The committee agreed that pharmacy will be intensely studied by four government agencies with at least fifteen different studies over the next three years.

The committee concluded that the following initiatives should be undertaken by the North Carolina Pharmaceutical Association in response to the Medicare Catastrophic Bill:

1. A study should be conducted to analyze what it costs a pharmacy to participate in the program, e.g. checking patient eligibility may take considerable time.
2. The association should also discuss how senior citizen prescription discounts will be affected by the bill.
3. How Medicare/Medicaid crossover problems will be handled, and
4. How mandatory counseling will be implemented and monitored?

The committee also reviewed and discussed physician dispensing, mail order prescription service, and discriminatory pricing. The committee concluded that the association should mount an education program for consumers on the pharmacists role in society and the delivery of health care and the services that a pharmacy should offer. In addition, the association needs to construct an education program for practicing pharmacists showing them the importance of delivering counseling and other pharmacy services.

It was also concluded that the association should:

1. Maintain a file on newspaper clippings and journal articles on physician dispensing and mail order prescription programs.
2. Survey practicing pharmacists for their feelings towards mandatory counseling.
3. Conduct a study comparing the proportion of patients in mail order prescription programs between stores which delivers counseling services and those that do not.
4. Take a proactive stance towards the delivery of pharmaceutical services, i.e., mount consumer/pharmacy education programs on the value and variety of these services.
5. Take a proactive stance towards mail order prescription plans and physician dispensing.

The committee concluded after discussing discriminatory pricing, that the association should support the NARD in its efforts to "guarantee equal access for retail pharmacy and its consumers to prices for similar pharmaceutical goods and products on the same terms as other purchases in the market place." To that end the committee recommended that NCPhA:

1. Support NARD in hearings on the unfair and inflationary impact of multi-tier pricing practices on consumers.
2. Support legislation to eliminate price discrimination to competitors whether for profit or commercial or nonprofit with the exception of charity aid to indigents.
3. Support H.R. 273, which would require registration of non-profits desiring discriminatory charitable prices for drugs and devices.

Respectively submitted.

Jerry Brunson
William Edmondson
Jean Paul Gagnon, Chairman
Jerry T. Gaylord
Seymour Holt
James McAllister
Whitaker Moose
William Randall
Milton Skolaut
Joseph Whitehead

REPORT OF THE ACADEMY OF CONSULTING PHARMACY

The Academy of Consulting Pharmacy session

Continued on page 32

CONSULTING PHARMACY REPORT

Continued from page 31

at the 1989 N.C.Ph.A. Convention was held on Saturday, May 20. A small but dedicated group met from 2:30 to 4:30 p.m. The meeting included the presentation of data from a recent survey of N.C. Facility Administrators, a discussion of the recent American Society of Consultant Pharmacists meeting at Hilton Head, and an open discussion about how to increase participation at meetings of the Academy.

Charles Pulliam moderated the session and presented data showing that facility administrators in North Carolina endorse specialized continuing education programming for consultant pharmacists. In fact, more than 75 percent feel this should be an annual requirement. Perhaps this view was driven by the fact that 97 percent believe the consultant pharmacist should be giving drug therapy advice to physicians and nurses taking care of the elderly.

Ernie Hargett reviewed the sessions and issues of the recent American Society of Consultant Pharmacists meeting at Hilton Head. More than 600 attended and the changing face of consulting pharmacy was evident in the variety of services represented, both in attendance and on the program.

Following these presentations the group discussed the pending long-term care facility interpretive guidelines from HCFA. These will go into effect on August 1, 1989. Those present had an opportunity to look over sections of an April 7, 1989 draft of the interpretive guidelines and agreed there are several areas of concern, particularly with some rather inflexible standards in several instances. A hearing on the draft was scheduled for May 22, 1989, in Baltimore, Maryland.

A survey of Academy members regarding their C.E. programming interests, preferred meeting sites and dates, and willingness to be nominated for an elected office was planned. A preliminary plan to meet during the N.C.S.H.P. Fall Seminar was approved.

Charles Pulliam

REPORT OF THE FINANCE COMMITTEE

The Finance Committee of the North Carolina Pharmaceutical Association for the year 1988-89

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was L.M. Whaley, Chairman, Howard Q. Ferguson, Albert F. Lockamy, Julian E. Upchurch, Ralph H. Ashworth, Robert B. Hall, Henry L. Smith and A.H. Mebane.

The Committee met at the Association office November 17, 1988 to review the year to date financial data and to prepare a budget for 1989. The budget was prepared and presented to the Executive Committee of the Association and was adopted.

The next meeting of the Finance Committee was held at the Association office April 18, 1989. The purpose of this meeting was to review the audited financial statement of the association.

After reviewing the financial statement of the Association the Finance Committee found everything to be in order. Following you will find pertinent financial data from the report for the North Carolina Pharmaceutical Association General Fund.

NORTH CAROLINA PHARMACEUTICAL ASSOCIATION GENERAL FUND

Income	
Dues	147,148.50
Other Income	135,010.85
Funds Transfer	13,880.51
Total Income	**$296,039.86**
Expense	
Salaries—Fringes	105,841.02
Operating Expenses	190,198.84
Total Expense	**$296,039.86**

REPORT OF THE ENDOWMENT FUND, INC.

The North Carolina Pharmaceutical Association Endowment Fund Annual fund raising dinner was held at the Kenan Center of the University of North Carolina in Chapel Hill, Saturday, November 5, 1988.

We had 60 people in attendance and a total of $12,825.00 was raised for the fund. We now have sixteen (16) Endowment Fund Members and 66 Sustaining Members. The fund-raising dinner was considered a success and the committee voted to continue the annual fund raising dinner.

The Board of Trustees met in the Association office November 29, 1988. The financial position of the fund was reviewed and it was decided to wait until the next meeting to make any changes in the investments of the fund.

During this year an individual has indicated that he and his wife are leaving to the NCPhA Endowment Fund a substantial contribution in the wills. The Endowment Fund will administer this contribution as a designated fund and according to the wishes of the donors.

After discussion it was decided that it is in the best interest of the Association and the fund members and donors to incorporate the fund as a separate non-profit, tax exempt corporation.

The Secretary of State issued a charter to "The North Carolina Pharmaceutical Association Endowment Fund, Inc." on February 20, 1989. The original Board of Directors as listed in the articles of incorporation were, Robert B. Hall of Mocksville, NC; Howard Q. Ferguson, Randleman, NC; L. Milton Whaley, Durham, NC. We are in the process of applying to the Internal Revenue Service for tax exempt status.

The Board of Directors held the organizational meeting of the corporation at the Association office April 18, 1989, additional directors were appointed and officers elected and the Board now consists of the following:

President L.M. Whaley, Durham, NC
Vice President Keith Fearing, Manteo, NC
Secretary-Treasurer A.H. Mebane, Chapel Hill, NC
Marshall Sasser, Smithfield, NC
Frances Rader Lena, Dallas, TX
Robert B. Hall, Mocksville, NC
Howard Q. Ferguson, Randleman, NC
Julian Upchurch, Durham, NC
Ralph Ashworth, Cary, NC
Albert Lockamy, Raleigh, NC

Your Board of Directors at the April 18, 1989 meeting also discussed the investment philosophy of the fund. After discussion it was decided that the investment goal was to achieve maximum income and to protect principal. To achieve this the Board directed the Treasurer to invest 90% to 95% of funds in the U.S. Treasury Notes with three to ten years maturity and the balance in cash or cash equivalents.

A dinner honoring the retirement of Ralph P. Rogers, Jr. was held in Chapel Hill, Saturday April 22, 1989. The funds from this dinner will become a designated fund within the Endowment Fund. The income will be used for pharmacy student scholarships.

The Board reviewed the available dates for the Endowment Fund Annual dinner and selected Saturday, October 21, 1989 as the date.

Following is the financial position of the fund as of December 31, 1988.

Continued on page 35

GEER

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THE NORTH CAROLINA PHARMACEUTICAL ASSOCIATION ENDOWMENT FUND, INC.

General Endowment Fund	$155,953.79
Ralph P. Rogers, Sr. Scholarship Fund	18,605.64
W.J. Smith Speaker Fund	5,181.01
J.S. Stewart Scholarship Fund	8,627.83
Total	**$188.368.27**

The Members of the Board of Directors are very proud of the progress the fund had made and is making, and with your help we will continue to have success.

Respectfully Submitted,
L. Milton Whaley
President

Howard Q. Ferguson — Julian E. Upchurch
Albert F. Lockamy, Jr. — Robert B. Hall
Ralph H. Ashworth — Henry L. Smith

REPORT OF THE STATE LEGISLATION COMMITTEE

At the fall meeting of the Legislative Committee, which was held at the Institute of Pharmacy in Chapel Hill. The following members and advisors were present:

Jimmy S. Jackson, Chairman — Bill Jackson
Bill Edmondson — Benny Ridout
Paul Bissette — David Work
Truman Hudson — John Henley
Jack Watts — W. Keith Elmore

The Chairman reminded the Committee that the association while convened in Boone, NC had voted to seek legislation help in extending the terms of Board Members from 2 (two), 2 (two) year terms to 2 (two), 5 (five) year terms; if so elected. The Committee voted to pursue legislation to extend the terms.

At the meeting, there was a lengthy discussion of the physician dispensing issue, which was in court at the time. The physicians challenged the Board's authority to require a personal appearance before the board for licenses and also the board's authority to charge a fee. It was decided to adopt a "wait and see" position on this issue.

At the meeting Mr. Mebane, Mr. Ridout and Mr. Henley informed the Committee as to the status of the House of Representative which had just witnessed the joining of forces of certain Democratic Representatives with the Republicans to form a pact which overthrew Liston Ransey, long-time speaker of the House and put into power Rep. Joe Mavretic as Speaker.

Due to the uncertainty within the House, the Committee voted not to pursue strengthening of the physicians dispensing issue during this legislative session.

Also present at the meeting, was Dr. David Work, Secretary of the State Board who was asked to comment on issues concerning the Board.

The Committee was represented by Mr. Mebane, Mr. Lockamy, Mr. McBride, Mr. Edmondson, and Mr. Jackson at a legislation planning session held by the NC Retail Merchants

Continued on page 36

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STATE LEGISLATION REPORT

Continued from page 00

Association. All factions of pharmacy were represented and support was pledged to the Retail Merchants Association in its effort to recover some fee for merchants collection of Sales Tax.

Cooperation between the association and the Pharmacy Network has been helpful in deterring a mail order prescription plan for state employees; the issue is still however a threat.

The Spring Committee meeting was held at the Kerr Drug Store Office North Raleigh with the following members present:

Jimmy Jackson	Benny Ridout
Bill Jackson	Billy Smith
Jack Watts (Pharmpac)	Paul Bissette

Virgil McBride (Legislation Engineer)

The Physician Dispensing Litigation involving the Board of Pharmacy having been decided in the physicians favor, the Committee looked into the possibility of strengthening the existing laws and under advisement of Mr. McBride, who pointed out the undecided outcome of such a venture, it was decided not to pursue the issue in this session.

Mr. McBride advised the Committee that the two Board of Pharmacy Bills (perdiem increase and the terms of the Board extension) had passed the House with Rep. B.P. Woodard's help and were now in the Senate.

Other Bills which have received the committee's interest are senate 803 and Hb 1120 which apparently will receive no action in this session.

During the course of the year, the Chairman met on two occasions with a Committee made up of drug wholesalers, manufacturers, retailers, and Mr. Bob Gordon and Commissioner Jim Graham to discuss what actions should be taken in the next session to bring our state in the compliance with the federal drug diversion bill. Dr. Bill Edmondson, Glaxo, sponsored the breakfast with the commissioner at Glaxo's Corporate Headquarters at Research Triangle Park.

Our state has now become a two party state. With the joining of forces between Democrats and Republicans in the House of Representatives occurring, no majority has arisen.

The coalition has some 60 plus votes and the old power base some 58 to 59 votes. This near balance makes the passage of any controversial bill by the house most difficult. As one lobbyist put it, "the 1989 legislative year will be an excellent year in which to defeat a bill and a year in which to pass a new bill will be almost impossible."

However, the Committee feels comfortable that the two Board of Pharmacy bills will pass, but deeply regrets that the Physician Dispensing Bill could not be strengthened. We urge that all pharmacists strengthen their relationship with their elected officials because as medical costs continue to rise more and more, pressure will be put on our industry.

Our lobbyist advises that to successfully pass a stronger physician dispensing bill, our expenditure through Pharmpac will need to more than quadruple. Please continue your support of Pharmpac.

Special thanks for their help during the year go to Mr. Bill Rustin, NC, Retail Merchants Associations; Dr. Bill Edmondson, Glaxo; Dr. David Work, Board of Pharmacy; Billy Smith and Bill Jackson who made special efforts on the Committee's behalf.

Respectfully Submitted,
Jimmy S. Jackson
Chairman

W. Keith Elmore	William H. Edmondson
John T. Henley	Gary Faulkner
William D. Smith	William A. Jackson
M. Keith Fearing, Jr.	Paul B. Bissette, Jr.
Stephen R. Novak	Bradford V. Ligon
Jack G. Watts	C.B. Ridout
Barney Paul Woodard	Franklin E. Williams

Committee Reports not appearing in this issue will follow in succeeding issues.

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CAMPBELL UNIVERSITY REPORT

Continued from page 10

was Dr. Fred Cox. Diana Maravich was also one of three students nation-wide selected for a Kappa Epsilon Scholarship. Dr. Ellen Underwood, Dr. Connie McKenzie, and Lynn Graham, Pharm.D. candidate, recently published an outstanding article on H_2-antagonists in the *U.S. Pharmacist.*

We have 100% student membership in the North Carolina Pharmaceutical Association and 80% membership in the American Pharmaceutical Association. Joe Moose, winner of the patient counseling competition sponsored by the Academy of Students of Pharmacy at Campbell, and thirteen other students attended the APhA Annual Meeting in Anaheim, California. Numerous students are participating in the National Association of Retail Druggists.

In summary, our mission is to train pharmacists in a Christian environment to meet existing and future health care needs. The charter class of Campbell University is exemplary of this mission. They are concerned, caring individuals who are committed to serving their fellow man. I believe the Class of 1990 will be a group that we can *all* proudly say graduated from Campbell University School of Pharmacy in North Carolina.

ASP-CAMPBELL REPORT

Continued from page 11

Campbell to the pharmaceutical community. This class of 46 Pharm.D.'s will be representing a new beginning in pharmacy for the state of North Carolina and the nation.

I'd like to thank our advisor, Dr. Wiser, Dean Maddox, Dr. Teat, my officers, and former President Joe Moose for their help with ASP this year. I'd also like to give a more personal thanks to Bill Mast.

UNC-CH REPORT

Continued from page 13

The 42nd Annual Meeting was held September 14. The morning session was held in Beard Hall where the academic and service programs as well as student demographics were reported. Visits to special laboratories were conducted. Fiscal year 1987-88 was a banner year for extramural support for the School which exceeded $2 M.

The afternoon business session consisted of the audit report and solicitation drive report. The 29 endowment gifts, 958 individual gifts and 4 corporate gifts ($30,397 endowment and $107,366 expendable) totaled $137,763. This was a decrease of about $46,000 from FY 1986-87.

The four directors elected by the membership of NCPhA with terms ending in 1992 were Paul Bissette, James Creech, Mitchell Watts, and William Wilson. The two members elected by the Directors were Barney Paul Woodard and Joe Whitehead.

Expenditures for 1987-88 were discussed and the 1988-89 budget was adopted. Dean Miya indicated underspending of the 1987-88 allocation. The 1988-89 budget is $106,000.

Linked with the Foundation fund-raising was the discussion of regional receptions with the Dean. As of the end of April 1989 three successful such meetings have been held in Charlotte, Cary, and Princeton.

The Foundation has been a driving force for the pursuit of excellence. We enjoy our present stature as a comprehensive School of Pharmacy, in part, through the aegis of the Pharmacy Foundation of North Carolina and all of you who support it. For this, I am eternally grateful.

ASP—UNC-CH REPORT

Continued from page 14

profession and, consequently, on society. Our chapter's membership continues to grow in numbers and in strength—yet, ironically, we strive to make those numbers become ONE as we unite, not only with other student chapters such as Campbell, but with our alumni and other health care professionals, as well. In doing so, we not only magnify our own profession, but accomplish our ultimate goal of health care.

TMA MEETING REPORT

Continued from page 27

Pres. Tom Terry III thanked everyone in the T.M.A. for their good support during the year. He stated that he had made many new friends in the pharmaceutical field as well as the Wholesale Drug field, and that all were still good friends. He then turned the gavel over to the new President, Rudy Snow.

The new President presented the outgoing President, Tom Terry, III with the traditional President's plaque.

President Snow stated that he had a promise from A. H. Robbins Co. and Glaxo for many new members. He stated that with everyone's help in 1989-90 the T.M.A. would go forward.

There being no further business, the meeting adjourned.

L. M. McCombs
Secretary & Treasurer

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Classified advertising is free to members. For nonmembers classified ads are 25 cents a word with a minimum charge of $5.00 per insertion. Ads are accepted for a single issue or specific time period only. The closing date for ad orders is the first of the month preceding the issue in which you are requesting insertion. Payment for ad orders will be billed. Names and addresses will be published unless an ad number for a blind ad is requested. In replying to blind ads, send to Ad Number ( ), *The Carolina Journal of Pharmacy,* P.O. Box 151, Chapel Hill, NC 27514. Telephone 1-800-852-7343 (in state) or (919) 967-2237.

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PHARMACIST WANTED: $36,548 per annum at Fort Bragg, North Carolina. Position requires work in the intravenous additives (I.V.) section, the unit dose section, and the outpatient pharmacy. Permanent part-time/full-time positions available. Excellent benefits. Reply to: Civilian Personnel Office, Recruitment and Placement Division, Attn: Jean Byrd, Fort Bragg, North Carolina 28307-5000 or call (919) 396-1402. EOE.

STAFF PHARMACISTS NEEDED: 152 bed community hospital. Duties include computerized order processing IV additives, chemotherapy, TPN preparation, pharmacokinetic consults and monitoring quality assurance assignments. Outstanding compensation package. Attractive schedule (only 1 weekend per month). Contact: Human Resources Department, Annie Penn Memorial Hospital, 618 S. Main Street, Reidsville, NC 27320. (919) 634-4549.

STAFF PHARMACIST OPPORTUNITY: The department of pharmacy services with Sampson County Memorial Hospital has available the position of staff pharmacists. Excellent working ability with medical and nursing staff. Activities include: antibiotic monitoring, TPN, aminoglycoside dosing and support for continuing education. Excellent work schedule includes 1 weekend per month with a 4-day work week. Three weeks paid vacation and more! Contact Patricia Britt, Director, Personnel: (919) 592-8511.

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PHARMACISTS WANTED: Due to rapid growth Kerr Drug Stores now have positions available for pharmacists in Raleigh, Fayetteville, Charlotte, Durham, and Greenville. Kerr Drug offers opportunity for growth into store management. Excellent benefits. Send resume to Jimmy Jackson, P.O. Box 61000, Raleigh, NC 27661, or call (919) 872-5710.

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Continued on page 40

CLASSIFIEDS

Continued from page 39

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AUGUST 1989 VOLUME 69 NUMBER 8

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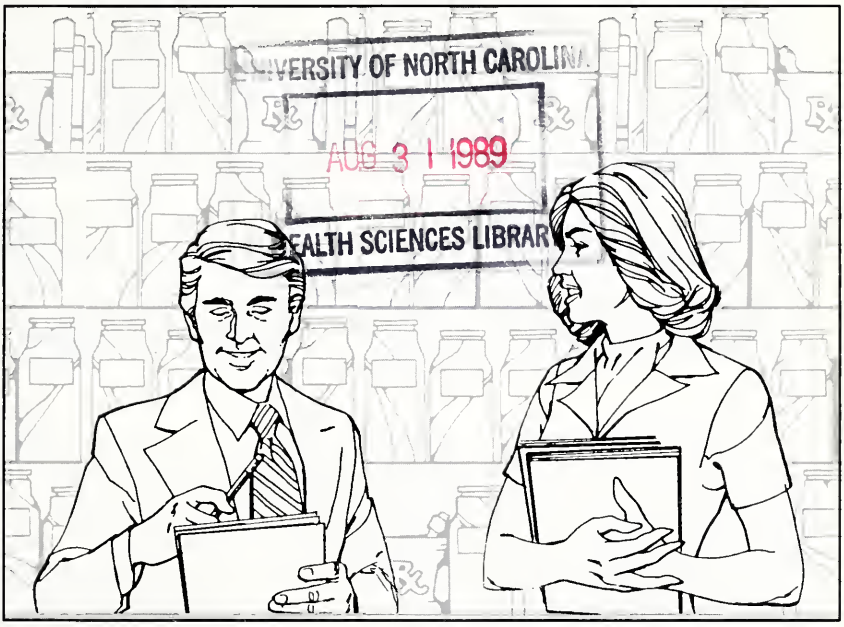

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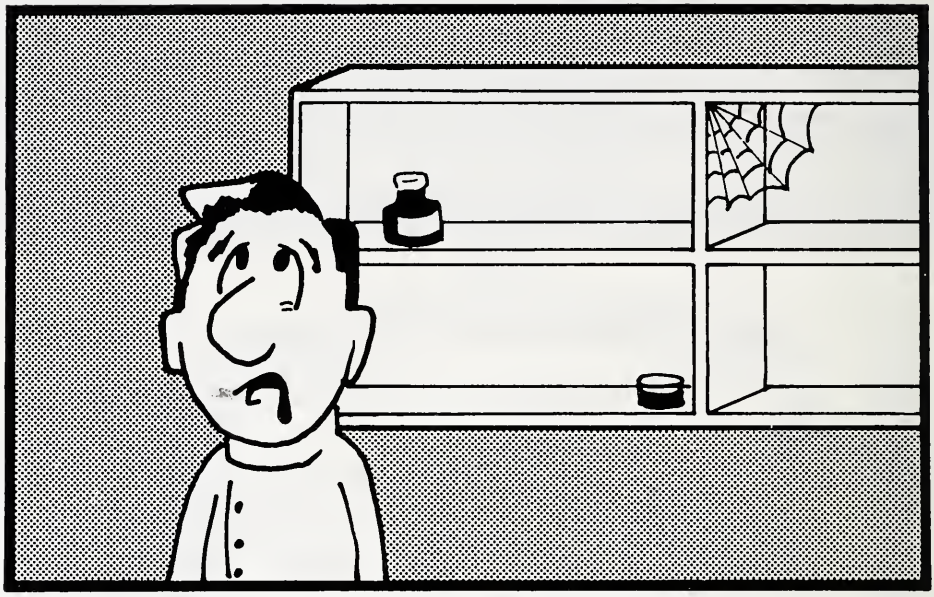

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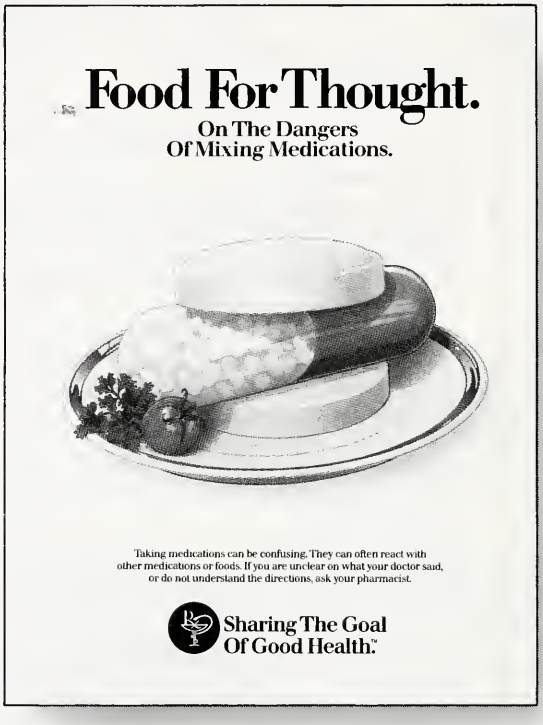
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PRESIDENT'S REMARKS

Your new Executive Committee met in Chapel Hill on June 4 and July 21. (The next meeting will be September 10.) We have appointed two task forces—the Task Force on House and Grounds and that will be chaired by Jack Watts and the Task Force on Policies and Procedures chaired by Marshall Sasser.

The Task Force on House and Grounds has been charged to come up with a plan to get our building repaired and grounds relandscaped. This will be an expensive project but these repairs must be made.

The Task Force on Policies and Procedures will develop a written document that will cover the activities of our staff, board members, and general members.

If you would like to provide some input to either of these task forces, contact Jack Watts at 444 Tarleton Ave., Burlington, NC 27215, H: 919-226-5861, W: 919-379-4396 or Marshall Sasser at 507 Hancock St., Smithfield, NC 27577, H: 919-934-1355, W: 919-934-2112.

Speaking of expenses, did you realize that only 48% of the Association's budget is derived from our membership dues? Other sources of revenues are derived from our insurance programs, journal advertising, and staff services. In the near future we may have to increase our annual dues to help offset the increasing expenses incurred from Association activities. A recent survey conducted by Purdue University School of Pharmacy in conjunction with Marion Laboratories, indicated that over 60% of the state pharmaceutical associations throughout the country have dues ranging from $100 to $225. That places our $75 membership fee well below the average of most states.

Daphne and I recently attended the South Carolina Pharmaceutical Association Convention in beautiful Asheville, N.C. They had a record attendance as we did in Myrtle Beach, S.C. I heard Calvin Knowlton of Amhearst Pharmacy of Lumberton, N.J. His topic was "The Medicare Catastrophic Coverage Act: A Not-So-Favorable Catalyst." A good bit of his presentation was alarming. One item was that the average gross margin percentage realized in community pharmacies will shift from approximately 32% (based on 1987 Lilly Digest Operating Statistics) to 15% by the year 2000. I don't think that many of us can stay in business with that small margin.

This Medicare Catastrophic Coverage Act is very complicated, but we must keep informed of the Act and do what we can to keep it more favorable to pharmacy. Our Association will do what it can to keep you abreast of any future changes. You must do your part by talking to our legislators in Washington and Raleigh. Write or call your legislator to keep them informed about pharmacy. **And keep yourself informed. Stay tuned in!**

I thank you for the opportunity to serve you this year as your President. I hope that you will call me or Al Mebane for any concern or issue you want to bring the Executive Committee.

Ralph H. Ashworth
President, NCPhA

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ADDICTION: DISEASE OR DISGRACE

By Dennis F. Moore, Pharm.D.

Those trained in the scientific method have difficulties with broad interpretation of what constitutes a disease. Yet as highly skilled, health care professionals, we pride ourselves in our ability to recognize and treat illnesses we characterize as diseases. If we perceive it as a disease, we attack it tenaciously seeking resolution to its destructive capacities. However, what we conceptualize as disease changes with time and scientific progress. Disease states that once were perceived as behavioral/spiritual problems, but are now recognized as disease entities, include syphilis and epilepsy. The disease of addiction is reeking havoc across our population, due to our failure to categorize it appropriately. Untold millions suffer because we characterize their behavior as disgraceful rather than disease. We as pharmacists sit in an excellent position to clarify this misperception.

As pharmacists, we have an additional hurdle to clear when we study addiction. We have traditionally studied addiction by looking at the drug involved without consideration of psychosocial issues. Thus, we identify the addict by prefacing the term with his drug of choice (alcoholic, heroin addict, etc.). This unfortunately stigmatizes the person depending upon our attitude toward the particular drug that he chooses. If the person happens to choose a drug that isn't considered a drug, discriminatory labeling is avoided. We can look with disdain on the opium addict; as he procures his drug. It's usually under the cloak of illegality. However, the smoker of tobacco (nicotine addict) defies such categorization even though he consumes one of the most addictive chemicals known. It is the contention of this author that until such psychosocial disparities are identified and considered, little progress will occur in reversing our profession's or our nation's drug use/addiction problem.

The following is a review of our classical disease models:

1) *The Infectious Disease Model*—this model contends that a particular type of agent is the cause of the disease entity.
2) *The Cellular Pathological Model*—this model is based on the contention that there is a defective cell or organ within the body.
3) *The Curative Model*—this model states that there is a singular pathological cause and that we can launch a magic bullet which will resolve the problem.
4) *The Diagnostic Model*—this model is based on the recognition that a constellation of symptoms constitutes a specific disease.

Addiction would be characterized under the diagnostic model. Alcoholism has long been characterized as a disease by the medical profession. However, general societal acceptance of this classification has not been forthcoming. We have even been more hesitant to characterize addiction to other drugs as disease. As professionals our readiness to do that with alcoholism probably resulted from the many physiological consequences of long term alcohol use, a condition seldom seen after chronic administration of many other drugs. Addiction is being recognized as a common illness regardless of the primary drug of choice. A factor that has precluded a proper recognition of addiction has been our preoccupation with physical dependency as being a necessary component of disease. It is now understood that physical dependency is neither necessary or sufficient to establish the presence or absence of addiction. Addiction is more realistically defined by compulsive drug intake, loss of control in face of the drug, and continued use in spite of obvious consequences. If one waits until physical dependency to a drug occurs, one is usually in advanced stages of the illness.

A comparison of alcoholism and diabetes provides interesting similarities. A pool of persons predisposed to these diseases occur in the population. That predisposition is probably genetically determined. Multiple disease forms can occur. The time of life in which the illness occurs determines, in part, the course and nature of the disease. Adaptation to its presence by the person varies greatly. Sociocultural factors play a role in its manifestations and in turn are influenced by it.

When confronted with diseases, the health care profession can usually diagnose and prescribe treatment that works. Even in diabetes, rarely are we confronted with physiological conditions that defy our ability to manage through appropriate interventions. Our failures more commonly are the result of the person's inability or unwillingness to accept the diagnosis and fol-

Continued on page 27

***Dennis F. Moore, Pharm.D.**, is Director of Woodhill Drug and Alcohol Treatment Center and Chairperson of the NC Pharmacist Recovery Network. Dr. Moore's address is Woodhill, P.O. Box 5534, Asheville, NC 28813, (800) 522-3695.*

RECOGNIZING IMPAIRED PHARMACISTS

Clues to Impairment (early signs marked with *)

NCPhA, in conjunction with NCSHP, sponsors a support group for pharmacists who recognize and want to conquer addictive and destructive behavior in themselves. The clues to impairment listed below may help you recognize this behavior in yourself or a colleague. The earlier the symptoms are recognized and acknowledged, the better the prognosis for restoration to a complete and fulfilling life. If you need help or know a pharmacist who does, call 1-800-522-3695 or 1-800-852-7343.

Home and Family

*Medicinal use of alcohol or drugs
*Mood swings or inconsistency
*Behavior excused by family/friends
Extreme temper
Heavy drinking
Drinking/Using activities seem more important than other activities
Children neglected, abused, in trouble, often with drugs
Fights, arguments, violent outbursts
Sexual problems
Withdrawal, isolation and fragmentation of social and family life
Family isolated from social support
Financial problems
Spouse in psychotherapy or taking psychoactive medication
Lack of problem resolution
Separation or divorce

Employment Applications

Frequent job changes or relocation
Unusual medical history
Vague letters of reference
Inappropriate qualifications
Time lapse unexplained in work
Inappropriate job now
Refusal of physical exam or spouse interview

Friends and Community

*Neglected social commitments
*Embarrassing behavior
Personal isolation
Overreaction to criticism
Exaggerates work accomplishments and finances
Drunk driving arrests
Legal problems
Lessening of ethical values
Unpredictability or unreliability

Physical Status

*Insomnia
*Personality and behavior changes
Amnesias
Multiple physical complaints and illnesses
Frequent ER visits and hospitalizations
Inappropriate tremulousness or sweating
Poor hygiene and appearance
Long sleeves in warm weather

Pharmacy

*Overwork
Disorganized schedule
Spasmodic work pace
Unreasonable behavior
Inaccessible to patients and employer
Prescription errors
Patient complaints
Frequent absences
Decreased workload and tolerance
Frequent days off for vague reasons
Taking sexual advantage of co-workers or customers
Filling illegal prescriptions
Taking and/or using drugs from pharmacy without a legal prescription or without follow-up by a physician
Taking and selling drugs to others or giving them to family or friends
Often late, absent or ill
Decreased work performance
"Pharmacy Gossip"
Unavailability
Alcohol on breath while in pharmacy

Adapted from the *Maryland Pharmacist*

THE N.C. PHARMACIST RECOVERY NETWORK (PRN)

The requests for assistance are varied: the wife of a pharmacist desires information as to how she can get help for her alcoholism, a pharmacist has just been confronted by the Board Inspector as to his shortages, and another family member wants to know how to deal with her pharmacist husband that has an addiction problem. The calls are varied as to need and urgency.

To many of us, the above situations seem remote and unimportant, but to a person in the midst of the crisis, being able to talk with someone that can offer assistance is a comforting and perhaps life-saving service. Since its inception, the Pharmacist Recovery Network (PRN) has offered assistance to many pharmacists and their families in similar situations.

The impetus for such a program began gaining momentum in the early 80's when many practitioners saw that current approaches were not having a major impact on deterring drug abuse among pharmacists. A survey of North Carolina pharmacists and a review of the N.C. Board of Pharmacy disciplinary actions revealed a problem so significant that other approaches had to be explored. The culmination of this effort was a program jointly endorsed by the North Carolina Society of Hospital Pharmacists and the North Carolina Pharmaceutical Association. Initially called the North Carolina Impaired Pharmacist Program, the name was promptly changed to the Pharmacist Recovery Network (PRN) to more accurately reflect the functioning of the program and to eliminate the negative connotations associated with the term "impaired."

The PRN program is based on the premise that factors which impair professional functioning can many times be identified and changed. Whether the source of the impairment is addiction, psychiatric or physical illness or stressful events occurring in ones social system, they can be overcome with appropriate support. While the majority of impairment among health professionals involves addiction, other factors may account for impairment and must be considered.

Committee Organization

The program is administered by a committee made up of interested volunteer pharmacists from throughout the state. It is comprised of a chairperson, a representative from each AHEC region and a representative from each of the state's schools of pharmacy. Additional participation is solicited from select pharmacists due to their special interest or geographic location.

The PRN committee operates under the sanctions of the NCPhA and the NCSHP. It has no direct ties with the N.C. Board of Pharmacy. However, the PRN Committee routinely works with the Board to help individual pharmacists.

Services Provided

The PRN program provides the following services:

1. Consultation for personal problems to pharmacists, their families, and pharmacy students. While not providing direct services, referrals will be made to appropriate community resources.
2. Education and training to pharmacists, pharmacy students, and pharmacy auxiliaries concerning impairment issues.
3. Intervention, referral to treatment and monitoring of aftercare services for pharmacists. If the problem is addiction, we require a contract be signed which involves a 30-month period of supervision.
4. Consultation to regulatory agencies, pharmacy organizations, and other health care professionals as to the issue of impaired health care professionals.

Confidentiality

Due to the delicate nature of impairment issues and the stigma attached to addiction/psychiatric illness/personal problems, confidentiality is essential. Information conveyed to other organizations by the PRN program is done only upon written authorization of the pharmacist involved.

Procedure for Accessing PRN

Individuals may voluntarily ask for assistance through PRN. Other mechanisms of referral are acceptable. Individuals may be reported to PRN by fellow professionals, non-professional coworkers, patients/customers, family members and regulatory agencies. Again, confidentiality is maintained and reports are validated before any action is taken. Informal phone conversations with the Chairperson are encouraged to gauge the appropriateness of a referral. The chairperson will also be able to put you in touch with a PRN representative in your area. One may access the PRN program by calling NCPhA at 1-800-852-7343 or by calling Chairperson, Dennis F. Moore, at 1-800-522-3695.

Activities to Date

The PRN committee has interfaced with many pharmacists and their families throughout North

Continued on page 27

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NC SCHOOLS OF PHARMACY ADDICTION ASSISTANCE & EDUCATION PROGRAMS

University of North Carolina at Chapel Hill School of Pharmacy
By Timothy J. Ives, Pharm.D.

In 1986, within the state of North Carolina, with support from the North Carolina Pharmaceutical Association and the North Carolina Society of Hospital Pharmacists, the Pharmacist Recovery Network (PRN) Committee was formed to serve as an advocacy group for impaired pharmacists in North Carolina. Within this committee, Dr. Timothy J. Ives serves as the representative for the Triangle area and for the School of Pharmacy at UNC.

In the summer of 1987, Dean Tom S. Miya of the School of Pharmacy at the University of North Carolina formed a task force consisting of Associate Dean George Cocolas, three fourth-year students and the PRN representative to draft a policy on chemical dependency. One of the members was a member of the national Task Force that developed the policy guidelines for chemically dependent students, faculty members and staff for the American Association of Colleges of Pharmacy. The AACP Guidelines were used as a template for developing a School of Pharmacy policy. A long process ensued requiring review by many individuals and groups such as the Vice Chancellor for Health Affairs, University Legal Counsel, and the Director of the Student Health Service to ensure due process and the best treatment plan available at UNC. The final draft of the UNC-CH Policy on Impairment of Students due to Substance Abuse was submitted to and approved by both the Dean's Advisory Committee and the Student Senate within the School of Pharmacy. A similar policy for faculty members and staff is pending.

As a result, during the 1988-89 academic year, the UNC School of Pharmacy Committee on Impairment was formed and is composed of the following individuals: two members from each of the three undergraduate classes, one representative from the Graduate and Pharm.D. students, and two faculty members. One of the fourth-year students and one faculty member serve as Co-Chairs of the Committee. The basic intent to this Committee is to serve as an advocacy group for students who require assistance in cases of chemical dependency. Educational efforts within the School of Pharmacy are provided through lectures on substance abuse in required courses (e.g., Introduction to Clinical Pharmacy Practice) and an elective course in Substance Abuse. Student groups such as the pharmacy fraternities (i.e., Kappa Psi, Kappa Epsilon and Phi Delta Chi) have also pledged their support to develop responsible use of alcohol, especially at their social functions. Based on a long standing tradition within the School of Pharmacy, members of the Drug Abuse Committee of the Academy of Students of Pharmacy (ASP) provide presentations to students in elementary, middle and high schools throughout the Piedmont Region as well as on the UNC-CH campus. Based upon the multitude of requests from school administrators in this area, as well as the positive evaluations from the schools where the ASP Programs have been presented, this program will continue to be offered for the near future.

During this first year, the Committee devoted much of its time to organizing and developing the skills necessary for its members to adequately deal with the problem of substance abuse/chemical dependency among students. With the approval of the university groups noted above, the Committee was in full operation.

To ensure a degree of quality and competency in their activities with chemically dependent individuals, the entire Committee underwent intervention training. One Committee member has had a long experience in intervening with and treating chemically dependent individuals. Copies of the approved revised policy for chemically dependent students was distributed to the undergraduate student body, with a brief discussion of the process for initiating an advocacy by the Committee. In a preventative manner, students in each class were told of the services available to them on campus should they need help in cases where personal stress or substance abuse/dependency was an issue. These announcements are made at key times in the semester when stress is thought to be high, such as

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ADDICTION ASSISTANCE

Continued from page 11

at midterm or final examination time. To date, four students have sought the assistance of the Committee, all during the Spring Semester. It is hoped that the Committee will have a continuous position in the mechanism of the student body activities. An informal assessment of the Committee has provided initial positive comments for the School.

In addition, a list of both treatment centers and aftercare programs, both locally and statewide, was prepared for use by the Committee in cases of student referral. This list has also been accepted by the University administration for use in a similar manner across the entire campus.

Although there is no guarantee that any pharmacy student or faculty will ever suffer from chemical dependency, these policies have been implemented to provide a supportive structure and environment to obtain the necessary treatment and rehabilitation without fear of retribution.

Campbell University School of Pharmacy
By Daniel W. Teat, Pharm.D.

From the inception of our School of Pharmacy in the Fall of 1986, we at Campbell University have been very cognizant of the problem of substance abuse in our nation. Unfortunately, this problem pervades the pharmacy profession in terms of practitioners and students as well.

Recognizing the existence of this problem, Dean Maddox sent the Director of Continuing Education to the University of Utah School on Alcoholism and Other Drug Dependencies before our first class enrolled. Subsequent to his training, that same individual has been given the assignment of discussing chemical dependence with incoming students during Pharmacy School Orientation. Students are made aware of the problem which exists among students of pharmacy across our nation, in addition to avenues by which they may present themselves for treatment of this problem.

A student drug abuse education team was formed to present programs dealing with substance abuse to the lay public, as well as professional audiences. This group is under the direction of the Drug Information Director. Included in the presentations of this organization are talks directed to pharmacy students, as well as other undergraduate students in our university.

Approximately one year ago, Dean Maddox created a new position of Associate Dean for Student Affairs. Part of the responsibilities of this individual is to direct programs for students. A program that is currently under formulation is a formal, step-by-step process which will enable impaired students or other concerned classmates to seek help for a chemically dependent individual. We are currently awaiting results from a comprehensive survey of our student body regarding the prevalence of substance abuse. In the meantime, it has been decided that programs for chemically dependent students in our school will very closely follow the guidelines established by the American Association of Colleges of Pharmacy.

We anticipate, at this time, to have a formal program established in the very near future. In the interim, students may present themselves to a faculty member of their choosing or the Campus Minister of Campbell University for counseling. Appropriate measures are then taken, via the Office of Student Affairs, to refer the student to an appropriate medical facility for treatment and follow-up. Based on that premise, students are not dealt with in a disciplinary fashion, but rather according to a policy keeping with the disease state concept of chemical dependency.

***Daniel W. Teat, Pharm.D.**, is Director of Admissions and Director of Continuing Education at the Campbell U. School of Pharmacy, Buies Creek, NC, and serves as a volunteer in the Pharmacist Recovery Network for the Campbell U. School of Pharmacy.*

CAMPBELL UNIVERSITY SCHOOL OF PHARMACY RECEIVES CANDIDACY ACCREDITATION STATUS

Campbell University School of Pharmacy has been granted candidacy accreditation for the Doctor of Pharmacy degree by the American Council on Pharmaceutical Education (A.C.P.E.) which met in Vancouver, B.C., on June 9-11, 1989. This is the first school of pharmacy in the United States in 38 years to go through the accreditation process by the A.C.P.E. The School of Pharmacy will be eligible for full accreditation in May 1990 when its charter class of 54 students graduates.

PERSONAL EXPERIENCES WITH DRUG ABUSE & CHEMICAL DEPENDENCY

The following anonymous authors wish to share their personal experiences dealing with drug abuse or a chemical dependency in hopes that you can be helped or can help someone you know to seek the necessary treatment.

A PHARMACIST OVERCOMES OWN DRUG ABUSE PROBLEM

In 1974 I finished pharmacy school and I was lost. Never having been good at making friends the break up of my class left me feeling alone. I went to work at the hospital with which my pharmacy school was associated and tried to build a social structure for myself.

It wasn't long after starting to work I found that if I was a little loose in whom I dispensed drugs to and what I dispensed to them I could have all the friends I wanted. This was great! At last an easy way to get people to like me and accept me. I had smoked a little pot and done some drinking after high school and never had any trouble so I figured I could join in with my new friends in getting high. What a mistake, you see I didn't know that I could become an addict.

I knew that as knowledgeable as I was drugs couldn't possibly hurt me. I knew proper dosages, effects, side effects, LD50's . . . you just name it. Nope, addiction couldn't happen to me, why I even set up guidelines for my usage. Rule #1 was that I would never use anything that was not packaged for injection by a reputable manufacturer. The trouble was that before too long there weren't enough injectables so I got rid of Rule #1 and came up with #2. Rule #2: Use only drugs made by reputable manufacturers mix them only with sterile water and run them through a 0.22 micron filter. When I finally found myself drawing up any garbage I could find through the filter of a cigarette I didn't even remember Rule #1.

From a little beginning of trying to make friends came a monstrous habit that within only a couple of years was destroying my life. I lost a job, I decided that everything was my friends fault so I gave them up, I lost the respect of my family and certainly strained their love, but I could not stop using drugs. I never believed in lying but I would lie daily for drugs. I have never believed that stealing is acceptable but I wouldn't hesitate to steal for what I needed. Nothing seemed to matter but finding my next fix. I violated almost every moral value I ever had and the battle between the way I was living and what I believed to be right and wrong was tearing me apart. Yet, I seemed to be unable to stop using drugs.

In 1982 I had the good fortune of entering a drug treatment center. I went with no idea of recovery but only the hope for a bit of rest. What a surprise awaited me.

At the center I was told that I didn't have a moral problem. I didn't have a will power problem. I wasn't even told that I was wrapped up in sin and the devil had me. No, I was told that I had a disease and that it was treatable and that if I was willing to give myself to the treatment program my life could be changed. I was introduced to Narcotics Anonymous and found that I was not the only person who ever had the feelings, fears and misgivings that I had. I saw other people who had had the same experiences that I had had but they were happy and could laugh. I had not laughed in such a long time that I determined that whatever these people had found I was willing to do anything it took to find it too.

That was almost seven years ago and today I haven't found it necessary to use drugs. I once thought that pharmacy and working around drugs was my problem but I do it every day successfully. Neither my friends or lack of same was my undoing. It was, I believe, just my disease.

Yes, addiction is treatable. A life does not have to be thrown away just because a person is sick. An addict can come back to the real world just as certainly as a heart attack victim can. I now own my own business, have a wife and three children, have the respect of the people I work with and feel that I have become a productive, responsible member of my community.

Today I work with the Pharmacy Recovery Network in North Carolina. I don't believe there are a lot of bad people working in pharmacy in our state but there are some sick ones and perhaps I can help one keep from going down the hellish road I traveled. As a pharmacist, I know pharmacy can't afford to lose well trained people and as an addict I help in order that I may be helped.

Continued on page 15

CONSIDERING YOUR REQUIRED READING, WE'VE MADE C.E. EASY TO FIND.

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That's why we're committed partners in helping you get the education you need as easily as possible. We sponsor an extensive list of the C. E. offered nationally, called the Pharmacists' Learning Assistance Network or P.L.A.N. We're also an approved provider of home study C. E. courses and nationally recognized live programs that are comprehensive, interactive presentations.

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It's all part of our ongoing dedication to bring you C.E. that meets today's changing needs and helps you realize your future.

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PERSONAL EXPERIENCES

Continued from page 13

CHEMICAL DEPENDENCY—A FAMILY DISEASE

"Your child should know better, you are pharmacists." Yes, our child had been taught to "Just Say No" to drugs and alcohol. But our child made a decision to experiment with chemicals when he was in his early teens and thus began our family's introduction to chemical dependency.

Our family consists of a mother, father, and two sons—"all-American" and average. The parents have been happily married for over twenty-five years. The older son is a college graduate and is pursuring his career. The younger son is recovering from his chemical dependency. We always considered ourselves to be the "all-American" family—loving, church-going, and hard working. Our lives were centered around our children. We went to PTA meetings, Cub Scout and Boy Scout events, Little League Baseball games, basketball games, swim meets, tennis matches, soccer games—anywhere the boys needed our support.

Our dream life was shattered when our younger son reached his teen years. We began to notice in him a tendency toward rebellion and withdrawal. We began our efforts to "fix him." First we tried Military School, then a local private school. Later our son told us that the new schools increased his drug connections from one small neighborhood to three states. Our son begged us to allow him to return to public school. We consented. He continued to excell academically and was once again an honor student—a delight to his teachers. However, by now, at fifteen he was coming home most weekends with an odor of alcohol about him. We would lecture, restrict, punish, and in the end just ignore him. Our family life was up and down. Many days we would say to ourselves "He can't be all bad, look at his grades, A's and B's, also look at his blue ribbons." Our son was a champion swimmer. But, he was living a dual life—later we learned that dual lifestyles are part of the disease of chemical dependency.

The magical sixteenth birthday arrived. A driver's license was easily obtained. Against the mother's wishes a car was purchased. Chemical dependency splits families. Our family had a rule —"If you have a car, you have a job to support the car." Our son *never* broke that rule. The job and the car produced good behavior for a while. We were elated. But, the bad habits soon returned—broken curfews, the odor of alcohol ever present, skipping school. We as parents were losing control.

One day, during conversation with a local policeman, the father was told that he could take civil action against our son and have him ordered into counseling and treatment. The civil suit was filed and out patient treatment began. Our son was the ideal patient. He attended all scheduled appointments and produced, on demand, clean urines—but not for long.

School ended and off to the beach went our son with our permission—but not our blessings. One Saturday night our son was arrested and placed in jail. However that visit was short and our son was back with his friends only to be arrested again on Monday night. His father made an emergency trip to South Carolina to get his son. We knew we were facing a long hot summer.

An arrest in July prompted us to seek long-term, in-patient treatment for our son. Our son had a terminal disease that must be treated.

During all of the bizarre behavior, we had been investigating different treatment programs. Our final choice was a long term center, out of state, that treated only adolescents. We began the final steps necessary to commit our son. Our son had told us that if we put him in treatment we would never see him again. We were willing to take the risk. One summer evening we began the long drive to the treatment center. On arrival the intake began. It was long and hard that August day. Finally our son signed himself into the program and began to assume responsibility for himself.

Our family began the *long* healing process. We, as parents, began to learn about the disease. We learned almost at once that our son's disease was not our fault. Our son had made a decision to use chemicals and he alone was responsible for his life.

As parents we were required to attend treatment sessions also. During one session we learned about the disease. The disease is a source of symptoms, not a symptom. It is on-going and non-curable. It can get progressively worse, and it can cause death. But, it can be treated. Another session was spent learning about the different roles that members of a chemically dependent family assume. Our family consists of one enabler, two heroes, and one chemically dependent person. These roles can change, and one of our

Continued on page 29

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In a Convenience Pak survey (N = 100)[1]

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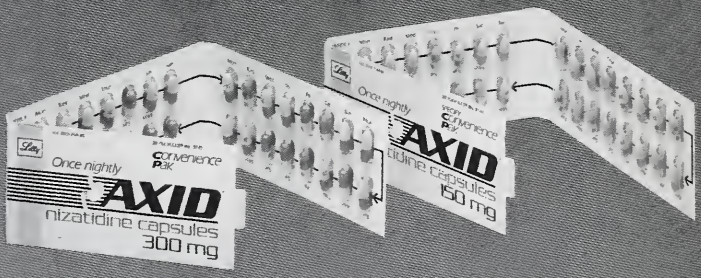

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Indianapolis, Indiana
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1. Data on file, Lilly Research Laboratories

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AXID®

nizatidine capsules

Brief Summary

Consult the package literature for complete information.

Indications and Usage: Axid is indicated for up to eight weeks for the treatment of active duodenal ulcer. In most patients, the ulcer will heal within four weeks.

Axid is indicated for maintenance therapy for duodenal ulcer patients at a reduced dosage of 150 mg h.s. after healing of an active duodenal ulcer. The consequences of continuous therapy with Axid for longer than one year are not known.

Contraindication: Axid is contraindicated in patients with known hypersensitivity to the drug and should be used with caution in patients with hypersensitivity to other H_2-receptor antagonists.

Precautions: *General* — 1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Because nizatidine is excreted primarily by the kidney, dosage should be reduced in patients with moderate to severe renal insufficiency.

3. Pharmacokinetic studies in patients with hepatorenal syndrome have not been done. Part of the dose of nizatidine is metabolized in the liver. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests — False-positive tests for urobilinogen with Multistix® may occur during therapy with nizatidine.

Drug Interactions — No interactions have been observed between Axid and theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450-linked drug-metabolizing enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increases in serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility — A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice; although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a two-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy — Teratogenic Effects — Pregnancy Category C — Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus and at 50 mg/kg it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers — Studies conducted in lactating women have shown that <0.1% of the administered oral dose of nizatidine is secreted in human milk in proportion to plasma concentrations. Caution should be exercised when administering nizatidine to a nursing mother.

Pediatric Use — Safety and effectiveness in children have not been established.

Use in Elderly Patients — Ulcer healing rates in elderly patients are similar to those in younger age groups. The incidence rates of adverse events and laboratory test abnormalities are also similar to those seen in other age groups. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of nizatidine included almost 5,000 patients given nizatidine in studies of varying durations. Domestic placebo-controlled trials included over 1,900 patients given nizatidine and over 1,300 given placebo. Among reported adverse events in the domestic placebo-controlled trials, sweating (1% vs 0.2%), urticaria (0.5% vs < 0.01%), and somnolence (2.4% vs 1.3%) were significantly more common in the nizatidine group. A variety of less common events was also reported; it was not possible to determine whether these were caused by nizatidine.

Hepatic — Hepatocellular injury, evidenced by elevated liver enzyme tests (SGOT [AST], SGPT [ALT], or alkaline phosphatase), occurred in some patients and was possibly or probably related to nizatidine. In some cases, there was marked elevation of SGOT, SGPT enzymes (greater than 500 IU/L) and, in a single instance, SGPT was greater than 2,000 IU/L. The overall rate of occurrences of elevated liver enzymes and elevations to three times the upper limit of normal, however, did not significantly differ from the rate of liver enzyme abnormalities in placebo-treated patients. All abnormalities were reversible after discontinuation of Axid.

Cardiovascular — In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

CNS — Rare cases of reversible mental confusion have been reported.

Endocrine — Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to Axid. Impotence and decreased libido were reported with equal frequency by patients who received Axid and by those given placebo. Rare reports of gynecomastia occurred.

Hematologic — Fatal thrombocytopenia was reported in a patient who was treated with Axid and another H_2-receptor antagonist. On previous occasions, this patient had experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental — Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity — As with other H_2-receptor antagonists, rare cases of anaphylaxis following administration of nizatidine have been reported. Because cross-sensitivity in this class of compounds has been observed, H_2-receptor antagonists should not be administered to individuals with a history of previous hypersensitivity to these agents. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other — Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine administration have been reported.

Overdosage: Overdoses of Axid have been reported rarely. The following is provided to serve as a guide should such an overdose be encountered.

Signs and Symptoms — There is little clinical experience with overdosage of Axid in humans. Test animals that received large doses of nizatidine have exhibited cholinergic-type effects, including lacrimation, salivation, emesis, miosis, and diarrhea. Single oral doses of 800 mg/kg in dogs and of 1,200 mg/kg in monkeys were not lethal. Intravenous median lethal doses in the rat and mouse were 301 mg/kg and 232 mg/kg respectively.

Treatment — To obtain up-to-date information about the treatment of overdose, a good resource is your certified regional Poison Control Center. Telephone numbers of certified poison control centers are listed in the *Physicians' Desk Reference (PDR)*. In managing overdosage, consider the possibility of multiple drug overdoses, interaction among drugs, and unusual drug kinetics in your patient.

If overdosage occurs, use of activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance.

PV 2096 AMP [013089]

Eli Lilly and Company
Indianapolis, Indiana
46285

Additional information available to the profession on request.

Axid® (nizatidine, Lilly)

Axid® (nizatidine, Lilly)

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PharmaDates

1989

September 7—Woman's Auxiliary Executive Committee Meeting, Institute of Pharmacy

September 10—NCPhA Executive Committee Meeting, Institute of Pharmacy

September 18—Board of Pharmacy Reciprocity Examination, Institute of Pharmacy

September 19—Board of Pharmacy Meeting, Board of Pharmacy

September 20-21—NCSHP Fall Seminar, Greensboro

September 24—NCPhA Pharmacy Practice Seminar, Wilmington

October 5—Woman's Auxiliary Fall Convocation, Institute of Pharmacy

October 8—Upjohn Grant Committee Meeting, Institute of Pharmacy

October 8-14—NC PHARMACY WEEK

October 11-15—Pharmacy in the 21st Century, Williamsburg, VA

October 16—Board of Pharmacy Reciprocity Examination, Institute of Pharmacy

October 16—Tripartite Committee Meeting, Institute of Pharmacy

October 17—Board of Pharmacy Meeting, Board of Pharmacy

October 21—Endowment Fund Dinner, Kenan Center, Chapel Hill

November 11-15—NARD Annual Convention, San Antonio, TX

November 20—Board of Pharmacy Reciprocity Examination, Institute of Pharmacy

November 21—Board of Pharmacy Meeting, Board of Pharmacy

December 3-7—ASHP Midyear Clinical Meeting, Atlanta, GA

1990

March 10-14—APhA Annual Convention, Washington, D.C.

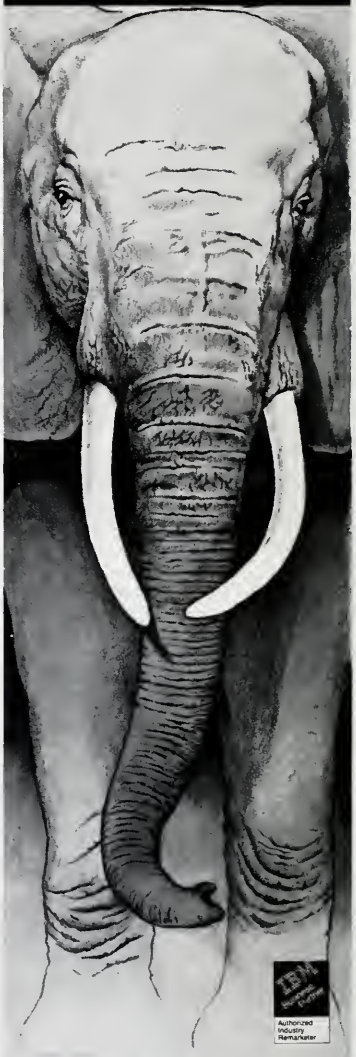
March 22—NCPhA Socio-Economic Seminar, High Point

May 23-26—NCPhA Annual Convention

June 2-6—ASHP Annual Meeting, San Diego, CA

October 20-25—NARD Annual Meeting, Nashville, TN

Elephants may never forget, but some patients do.



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AROUND THE STATE

This column features news briefs about people and events related to pharmacy around the state. The NCPhA staff welcomes your comments and any contributions you wish to make to this column. Photos are also welcome. Send us your news!

Awards

Dr. Albert Jowdy, professor emeritus at The University of Georgia College of Pharmacy and former UNC School of Pharmacy faculty member, is the first recipient of the Albert W. Jowdy Preceptor Award. The award was presented by the Southeastern Conference for Postgraduate Pharmacy Education at the group's 20th annual meeting. Jowdy was honored for his outstanding leadership and dedication to pharmacy residency programs. He has also been instrumental in promoting and sustaining the development of the Conference since its inception in 1969.

Bruce Canady, Wilmington, recently received the Merck Sharp & Dohme Pharmacist Achievement Award. Canady was recognized for his service as President of NCSHP and for his contributions to the field of hospital pharmacy.

Ron Gobble of Salisbury and **Max Gardner Reece Jr.** of Siler City have been nominated for the 1989 President's Volunteer Action Award and the Revco Volunteerism Award. Gobble's volunteer efforts center around the Hospice of Rowan County. In addition to being president of its board of directors, Gobble visits patients at home to assess their pharmaceutical needs. Reece has been widely involved in civic activities in Chatham County. During his term as president-elect for 1988-89, his Rotary Club raised over $40,000 for the Chatham County Hospital and over $7,000 for a local Drug Awareness Program.

1989 winners of the Medicine Shoppe International's Good Neighbor Medallion are: **Gene Braddy** of Winston-Salem, **Barry Gates** of Mt. Airy, **Doug Guider** of New Bern, **Tom Moore** of Salisbury, and **Jonas Moretz** of Hickory. Individuals are honored for their services rendered and community awareness programs.

Appointments

Steve Caiola, Chapel Hill, was appointed to the newly established Specialty Council on Nutritional Support Pharmacy Practice of the Board of Pharmaceutical Specialties (BPS). Nutritional Support Pharmacy Practice was first recognized as a specialty in pharmacy by BPS on October 14, 1988.

Carl D. Taylor, Ahoskie, owner of Taylor's Pharmacy in Gatesville and Boone-Taylor Pharmacy in Ahoskie, has been appointed to Planters Bank's Ahoskie city board.

Warrenton pharmacist, **Palmer W. "Woody" King Jr.** was elected to his third consecutive one-year term as president of the Warrenton Merchants Association.

In The News

Peggy and **Frank Yarborough**, owners of the Diabetes Care Center in Cary, are now franchising their business. The franchise package includes training, equipment, supplies, name, and marketing.

The first phase of Copperfield Plaza, a 400 acre, $1.3 million medical supply, pharmacy and therapy complex, opened in Concord June 11. Each business features state of the art equipment and contemporary medical services. **Mickey Watts**, **Bill Harris**, and **Bill Cranford**, all of Concord, are partners in the project.

Donnie Davis and his wife, **Gina Chamberlain Davis**, have purchased Clinic Pharmacy in Mooresville from Samual H. Price Jr. Clinic Pharmacy was established in 1898 as Miller Drug Company and moved from its downtown site to its present location beside Lake Norman Regional Medical Center in 1969. Donnie and Gina have renovated the store and have introduced new programs and merchandise.

Pharmacy Openings: Moose Drug Co. will open a new pharmacy at Copperfield Plaza in Concord. Of the four generations of pharmacists in the Moose family, **Whit Moose Jr.** will manage the store. A common reception area will be shared by H & M Medical Clinic and Moose Drug Co. Allen's Discount Drug, owned by **Mike Allen**, recently held its ribbon cutting

Continued on page 21

William R. Strozyk (right), a third-year pharmacy student at Campbell U., received a first place award in the Searle Fellowships in Pharmacy presented by the G.D. Searle Pharmaceutical Co. A co-award went to Fred M. Cox, Ph.D., (left), assistant professor of pharmacy administration at Campbell, for assisting Strozyk with the completion of his application portfolio. Both accepted their awards at the APhA Annual Meeting in Anaheim. Strozyk was selected on the basis of his educational achievement, professional involvement, leadership potential and an essay identifying areas to strengthen the pharmacist's role in patient counseling. Ronald Maddox, Dean, Campbell U. School of Pharmacy, is also pictured in the photo.

On behalf of the Eli Lilly Co., Sharon Green, a medical service representative for the company, presented a 100th anniversary commemorative apothecary jar to Mrs. Sue Holding, owner, of T.E. Holding Drugs in Wake Forest. Three generations of Holdings have owned and operated the drug store for a century. Sue is the widow of the late T.E. "Tommy" Holding III. Also pictured is the store's pharmacist, Bill Griffin.

AROUND-THE-STATE

Continued from page 19

ceremony at 903 W. Vernon Ave. in Kinston. The mayor of Kinston attended the ceremony.

APhA has announced the candidates for the Academy of Pharmacy Practice and Management (APPM) offices to be voted on by the Academy membership this fall. The following pharmacists from North Carolina have been selected by the APPM Committee on Nominations: **Albert F. Lockamy Jr.**, Raleigh, Chairman-elect, APPM Section on Community & Ambulatory Practice and **Dennis Williams**, Durham, Member-at-large, APPM Section Clinical/Pharmacotherapeutic Practice.

Kelly Cauley, Kinston, volunteers much of her time giving frequent talks to local community groups and area schools about drug abuse and prevention. She is employed by Eckerd's at the Plaza Shopping Center in Kinston.

Weddings

Michele Marguerite Strickland of Raleigh and **Stephen Wayne Moss** of Erwin were married May 20 at Hudson Memorial Presbyterian Church in Raleigh. Stephen is a graduate of UNC-CH School of Pharmacy. He is a pharmacist at Kerr Drugs. The couple lives in Raleigh.

Mary Michelle Setzer and Dr. Rubin F. Maness, both of Goldsboro, were married April 15 at St. Paul United Methodist Church. Mary is a UNC-CH School of Pharmacy graduate. She is chief pharmacist at Kerr Drugs. Rubin is a pediatrician and partner at Goldsboro Pediatrics. The couple resides in Goldsboro.

Martha Carol Muse of Carthage and **Paul McIntyre White** of Sanford were married April 22 at First Presbyterian Church. Paul is a pharmacist at Eckerd Drug in Sanford. Martha and Paul live in Sanford.

Connie Lynn Daughtry and David Thett Nance, both of Raleigh, were married May 7 at Sanders Chapel United Methodist Church in Smithfield. Connie, a UNC-CH School of Pharmacy graduate, is a pharmacist at Ashworth Drugs in Cary. The couple lives in Raleigh.

Susan Leigh Fulbright and Stephen McClesky Rogers were married April 22 at First United Methodist Church in Granite Falls. Both are pharmacists. Susan is a UNC-CH School of Pharmacy graduate and is employed at Thomas Rehabilitation Hospital in Asheville; Stephen is a USC School of Pharmacy graduate and is employed at St. Joseph's Hospital, Asheville. They live in Swannanoa.

Linda Susan Rhodes of Salisbury and Stephen Cantrell Deas III of Eatonton Ga., were married June 17 at First United Church of Christ. Linda is a UNC-CH School of Pharmacy graduate. She is a relief pharmacist in the Piedmont. The couple lives in Charlotte.

Robin Rene Watts and Darren Lee Tinney were married May 27 at Pleasant Grove United Methodist Church. Robin is a graduate of UNC-CH School of Pharmacy. She is a pharmacist with Revco Drug Stores in Charlotte. The couple lives in Fayetteville.

Suzanne Mobley and Paul Graham Jordan Jr., both of Raleigh, were married May 7 at First Baptist Church. Suzanne is a graduate of the UNC-CH School of Pharmacy and a pharmacist consultant at MediSave Pharmacies Inc. Suzanne and Paul reside in Raleigh.

Births

Laura and **Ken Vance** announce the birth of their daughter, Elizabeth Anne, born May 17. Elizabeth weighed 6 lbs., 10 oz.

Sally Berkes McGee and her husband, Peter, announce the birth of their son, Mitchel Cameron. He was born on May 16 and weighed 7 lbs., 15 oz. Sally graduated from UNC-CH School of Pharmacy in 1985. She is a pharmacist at Kerr Drug Store at University Mall, Chapel Hill.

AFFILIATE NEWS

The **Guilford County Society** of Pharmacists met on June 11, 1989 at the Greensboro/High Point Marriott. One hundred pharmacists and their guests enjoyed the 2nd Annual C.E. program and Pig Pickin' sponsored by Glaxo, Inc./Allen & Hanburys. Robert Fuentes, M.S., Pharm.D., Medical Service Director, Glaxo, Inc., spoke on "Inhalation Therapy for Respiratory Diseases."—*submitted by Frank Burton, Secretary/Treasurer*

The **Wake County Pharmaceutical Association** organized a Pig Pickin' on May 7, 1989 for pharmacists, manufacturing representatives and physicians. Despite the cool, rainy weather eighty persons in all attended the social gathering sponsored by Glaxo, Inc.—*submitted by Benny Ridout, President.*

WELCOME, NEW MEMBERS!

The following persons have joined NCPhA since the publication of our last journal issue. We are glad these pharmacists have joined their colleagues in the Association who are committed to preserving the future of pharmacy practice in North Carolina.

Denis Wood, Charlotte
Myra Brickell, Raleigh
Thomas F. Dabney, III, Charleston, SC
Stephen R. Jones, Wilmington
Jarrell R. Sigmon, Wrightsville Beach
Stephanie L. Perry, Chapel Hill
Alice E. Smith, Morehead City
Mike Thompson, Hope Mills
Libby D. McLemore, Fayetteville
Venita K. Sharma, Raleigh
Gregory A. Morris, Raleigh
Michelle Courtney, Rocky Mount
Linda M. Martin, Cary
Trent A. Beach, Chapel Hill
Lori P. Walters, Lumberton
Andrea Joy Gallagher, Greensboro
Pamela Jean Duncan, Chadbourn
Kim Adams, Asheville
Mark Aaron Umbarger, Danville, IL
Howard R. Lutz, Kings Mountain
Emily Adcock, Matthews
Frank C. Spencer, Jr., Clemmons
Robert E. Guy, Winston-Salem
Thomas F. Hughes, Chapel Hill
Luisa Andrade Spivey, Raleigh
Joseph Kim Koontz, Wilkesboro
Rhonda Johnson, Broadway
Joel Pippin, Chapel Hill
Russell Carroll, Willow Springs
W. Clark Doggett, Summerfield
Beverly Riley, Belhaven

WE ARE PLEASED TO ANNOUNCE THAT

CHRISTIAN L. RIDDLE

has joined us as a sales trainee. A graduate of Eastern Carolina University, Christian brings a contagious vitalilty and enthusiasm to our organization.

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FROM THE MAILBAG

These letters were sent to NCPhA by some of our members who were disturbed about a perceived "problem." In each situation, they decided not to remain indifferent. We would like to share with you the letters they initiated.

Dear Blue Cross and Blue Shield of N.C.:

I was most disturbed today when one of my clients, Mrs. ——, informed me that she had to change drug stores because of her insurance company. I have taken care of the prescription needs for Mrs. —— for over 10 years. She told me that she was very satisfied with the service that I had given her and her family over that period of time and told me that she hoped that I would not have any hard feelings toward her because she had to change drug stores. I asked her why she was changing and she said the only reason she was changing was that the insurance company said that she had to change drug stores because of the high cost of her medicine. She is afraid that the insurance company will cancel her policy if she does not change drug stores.

I tried to explain that I do not believe that the insurance company can or should require any policy holder to change drug stores but she is an elderly lady and is frightened that your company will cancel her policy—leaving her at the mercy of ever increasing health care cost.

Will you write to Mrs. —— and inform her that you will not cancel her policy and that she has the choice to deal with people she has grown to trust? I hate to think that she will have to go to the trouble of changing all her medications to another store because she misunderstood your statements urging generic drugs and reduced medical cost. I also personally and professionally resent the intrusion such requests make into the patient/pharmacist relationship.

Sincerely yours,
Mark A. Manship, Pharmacist
Medical Arts Pharmacy
328 Mulberry Street S.W.
Lenoir, NC 28645

Dear Mrs. ——:

Mr. Manship has written us about your discussions with him about drugs.

The message on your Claims Activity Summary to discuss generic drugs with your pharmacists and physicians was a simple suggestion. We will not cancel your coverage based on whether you purchase regular drugs or generic drugs. It was not our intent to lead you to believe it would be cancelled if you purchase only regular drugs. We apologize if you believed that we would cancel your coverage based on that message.

We are sure generic drugs are sold by Medical Arts Pharmacy. It is our experience that in most cases generic drugs are the same medicine as regular drugs. The cost is about 50 percent less. We also understand that many of the major drug companies also manufacture generic drugs.

You are aware that your premium rate has steadily increased over the last several years. All our rates have increased. Part of the increase has been new medical procedures such as liver transplants, open-heart surgery, etc. Other causes have been the increase in hospital and doctor charges and usage. Efforts are being made to control those costs. Increased drug charges has also been a part of rate increases.

Our net loss for 1987 was $67,911,000 and $74,496,000 for 1988. In spite of all the cost containment efforts underway, it has been necessary to increase rates charged our subscribers. This has now made the cost of health insurance such that many of our subscribers can no longer afford coverage. This has led us to believe that more effort must be made to control all costs. Encouraging the use of generic drugs is one of those efforts. An approach of overlooking or not using all available means of controlling all costs will result in continued rate increases.

I am aware you primarily wanted assurance your coverage would not be cancelled by us if you did not choose to use generic drugs. You have that assurance.

R.E. Martin
Staff Manager
Subscriber Services
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Mr. Thomas W. Field, Jr.
Chairman of the Board
PCS, Inc.
Phoenix, AZ 85072-2115

Dear Mr. Field, Jr.,

I am in receipt of your letter of June 15th, 1989. I hope you will allow me to pass on a few comments that came to mind as I read your letter.

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FROM THE MAILBAG

Continued from page 23

Actually I would have written a similar letter sooner but, as most independent pharmacists, my spare time is practically non-existant and what little there is of it is almost never spent in letter composing. It began to occur to me though that if you don't hear from us out there "in the trenches" that you will assume we are indifferent to what is going on and are willing to "take it on the chin."

Let me begin by saying that I consider AWP a non-discountable item. It is true that pharmacists can obtain a 10 to 12% discount from most wholesalers. This is true only if paid within 15 days. Otherwise the wholesalers feel entitled to confiscate this discount. We are not guaranteed to receive this discount. This becomes particularly difficult when the independent pharmacist has personal charge accounts, medicaid, PCS, and other third party accounts that frequently take longer than 15 days to pay up. The ten to 12% discount is just barely adequate compensation for stocking and paying taxes on this inventory. The receipt of this compensation is one of the only ways the pharmacist has been able to even half way keep up with inflation.

You state that health care expenses for GM were up 22% in 1988. If you'll check I'm sure you'll find the pharmacist fees accounted for almost none of that increase. Almost all of the increase in prescription expense can be traced to increases from the manufacturer, not the pharmacist. You are allowing and encouraging them to direct their efforts toward the wrong villain. Pharmacists have done more to help contain health care costs through encouraging use of generic drugs than any of the new "let's skin the pharmacist" fee schedules that can be dreamed up. If you really desire to lower cost to the provider, it can easily be done without bankrupting the pharmacists who support you. The proper approach to these companies should be as follows:

We can tailor a program to contain your pharmaceutical health care expense. The minimal that we should expect the pharmacist to accept is identical compensation to that of a welfare recipient. Would you like for your employees to receive identical to welfare services or would you like to compensate the pharmacist a little more fairly for his services. Now just ask them how much money do they want to spend and design the co-pay so that the company's out of pocket expenditure is what they desire. I would also encourage a large differential between generic and brand co-pay so as to encourage generic usage. One plan we serve has a $3 generic and an $8 brand name co-pay. Believe me for a $5 differential, they ask for generic every time. In reality, the company pays far less with a plan like that and no one gets butchered.

What good is it to have the recap machine if I have to sit down and figure on each prescription if I have been compensated at least equal to medicaid rates. In North Carolina, if I accept less from you, I have to extend those same prices to medicaid. So on each prescription I have to figure how much must be added to the co-pay to make total compensation at least equal to medicaid. As you might imagine this leads to some interesting conversations at the register when they thought they had a $3 co-pay and I charge them $3.54. I have to explain to them that the company they work for is too cheap to adequately pay for their medical prescription needs and are 54 cents short of even providing welfare compensation. I'm tired of playing the bad guy. In the future, I'm going to just tell it like it is and let them judge for themselves who the real villain is.

You could very easily remedy a lot of the pharmacist's problems by taking the "seldom traveled high road." There will always be someone out there who can make it a little shoddier and sell it for less. Don't be a partner in the travels of the low road. In the end we will all benefit from just saying no to unreasonable compensations.

By the way, I'm currently re-evaluting usage of the recap machine. What with everyone trying to cut my fees I don't think I can afford the 20 cent/Rx fee anymore and will soon be going back to paper claims. At least then you paid me 1 cent instead of me paying you 20 cents. That would be one way I could recoup 21 cents of my fee back—right?

I hope we can work through this together. PCS has in the past been a model for third party compensation. I guess that's why it's so disturbing to see you succumb to pressures to prostitute the pharmacy profession in order to get the business. When you are the leader—you set the standard.

Thanks for listening.

Sincerely,
Frank P. Purdy, R.Ph.
President
Dees Drug Store, Inc.
111 Wright Street
P.O. Box 427
Burgaw, NC 28425

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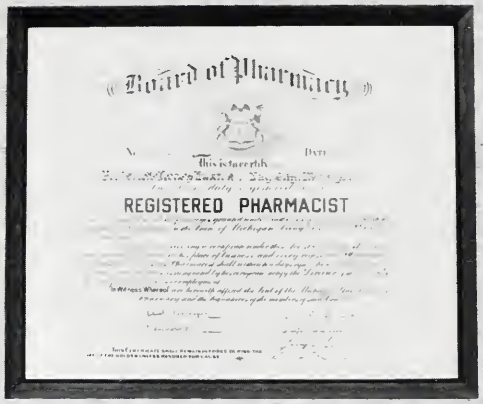

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ADDICTION

Continued from page 7

low accurately the prescribed treatments. When lack of stabilization occurs, our response to the person with diabetes varies considerably when compared to the addict.

With the diabetic, we tend to support and encourage this person even after repeated relapses which are brought on by the person's unwillingness or inability to follow said treatments. However, if the alcoholic relapses secondary to those factors, we seldom perceive it as anything other than his unwillingness and many times respond with negative emotion to his/her dilemma.

In treatment, I've never met a person who wanted to become an addict. They want to be users and abusers just like the rest of society. However, they find it impossible due to the bio-psycho-social consequences of their consumption. In a society where most all adults consume mood altering substances, those that cannot do it successfully are perceived as not "wanting" to do it successfully. However, I'm not sure we can classify all behavioral responses to a drug as being the result of "will." Could it be that some individuals have adverse behavioral responses to certain drugs as others do to adverse physical responses to a penicillin allergy? Our societal practices and individual attitudes concerning the importance of using mood altering substances tends to preclude this kind of conceptualization.

During the famous Lincoln-Douglas debates, Mr. Lincoln asked Stephen Douglas, "If a horse's tail was called a leg, then how many legs would a horse have?" Douglas responded "five." Lincoln reminded Mr. Douglas that calling a tail a leg does not make it so. When conceptualizing "disease" we may call a tail a leg but we think we know the difference between tails and legs and continue to maintain this subjective distinction during the process of social perception.

As pharmacists we can gain much and lose little by conceptualizing addiction as a disease. Addiction is preventable, identifiable and treatable. Let's move beyond lip service to the disease and move forward in claiming our proper role in addressing its devastating effects on both our clients as well as our colleagues.

PHARMACY RECOVERY NETWORK

Continued from page 9

Carolina in its short existence. We have active contracts with 12 pharmacists. There have only been two relapses, with one going back to treatment immediately. This rate of recovery is far greater than one expects from the general population of those completing treatment. However, the real measure of the program's success will be determined as the contracts mature. With 30 months of successful recovery completed, the incidence of permanent abstinence and recovery is increased. While it is unclear how many of these would have been successfully rehabilitated without PRN, it is apparent that we are salvaging professionals through this effort.

Challenges

The "conspiracy of silence" plagues the evolution of the program. We as professionals—as well as society at large—fail to recognize the signs and symptoms of addiction, the leading cause of impairment. When it is recognized, intervention, treatment and recovery is possible. To postpone dealing with an impaired colleague or employee for fear of the consequences only leads to a progression of the problem, with the resultant consequences being greater. The PRN Committee welcomes your comments as to how we can better support you as a professional.

If you would like to help your professional colleagues by becoming a volunteer for the NC Pharmacist Recovery Network, please contact Dennis Moore at (800) 522-3695 or (704) 253-3681 or Al Mebane at (800) 852-7343 or (919) 967-2237.

HOW-TO COMMUNITY PROGRAMS ON ILLICIT DRUGS

If you would like to get involved with helping your community deal with the illicit drug problem, you might consider talking to neighborhood groups or making information available in your pharmacy. Ready-made materials can be obtained to use for handouts and/or presentations from the following sources.

Pharmacists Against Drug Abuse (PADA) offers a pre-written speech, a pharmacist's training manual and fliers. For free info and material, call 800-667-3747.

Parents Resource Institute for Drug Education (PRIDE) can provide additional materials by calling 800-667-3747.

The educational materials are also available from NCPhA.

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PERSONAL EXPERIENCES

Continued from page 15

members became a lost child/passive adult. The enabler was the one that always offered excuses for the behavior of the chemically dependent person. The enabler had to learn to stop rescuing the chemically dependent family member. Heroes are independent, super responsible people that want perfection at all times. Our heroes had to learn to relax, and stop trying to be perfect. Our passive adult/lost child member slowly returned to the family as education continued. Other sessions were spent learning about tools that will help us during recovery. We learned how to use the *Twelve Steps of Alcoholics Anonymous*, how to pray and understand *The Serenity Prayer* and to understand the *Slogans* of *Alcoholics Anonymous*. We learned to "Let Go and Let God" and to live "One Day at a Time."

Our family was in treatment for fourteen months. It was long and hard, but treatment was one of the best things that ever happened to our family.

Our son graduated from high school after he completed treatment, and then returned to our home. He is scheduled to graduate from our Community College with a technical degree in August, and a few days later, he will enter the University of North Carolina.

Recovery will continue for the rest of our lives. Our son attends meetings of Alcoholics Anonymous several times a week. We meet with parents of children that are in treatment or have completed treatment.

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Continued on page 32

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Continued from page 31

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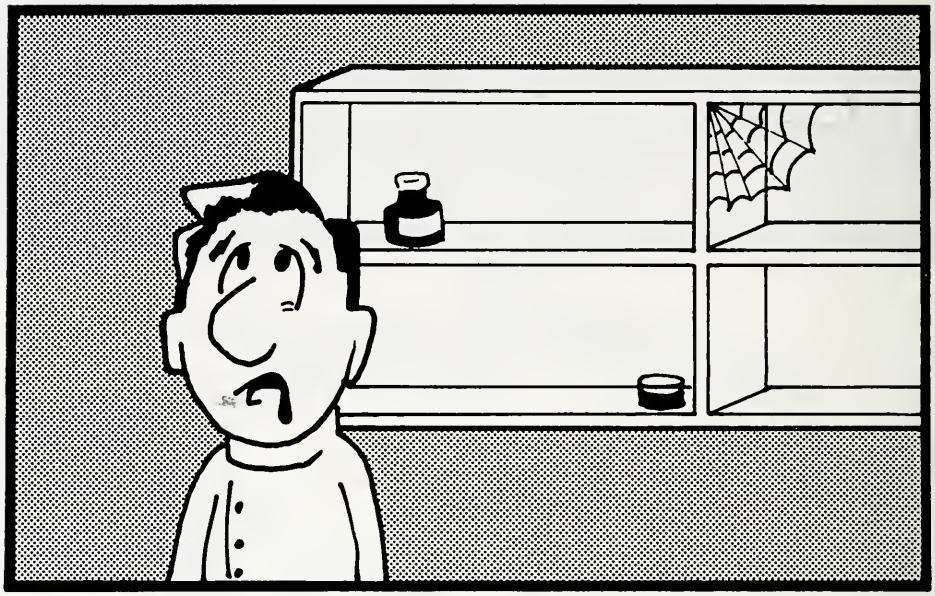

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TALK ABOUT PRESCRIPTIONS

M O N T H

1989 NC PHARMACY WEEK, OCTOBER 8-14

Volunteers Needed For Phone-In

The 1989 NC Pharmacy Week, October 8-14, is quickly approaching. Sarah Beale Cobb, Chairman of NCPhA's Public & Professional Relations Committee, is working closely with NCSHP to develop plans for the week-long event. *"Speak Up America: Talk About Prescriptions"*, designated as the theme for the 1989 national prescription month, has been adopted for NC Pharmacy Week.

Public relations packets will be obtained from the National Council on Patient Information and Education (NCPIE), which sponsors the national medication awareness campaign each October. Every pharmacy throughout the state will receive a public relations packet by mail in early September.

The traditional phone-in day, sponsored by Glaxo, has been expanded to four cities this year. Mall locations in Charlotte, Durham, Fayetteville and Raleigh will be the sites for the phone-in on Saturday, October 14. Pharmacists are needed to man the phones and answer questions from shoppers and passers-by. A variety of references will be available to assist pharmacists in answering questions. Media coverage for this event will be provided by local TV and radio stations.

We need your help to make this year's event just as successful as the previous years'. Please volunteer an hour or two of your time on Saturday, October 14. This is an opportunity for you to promote your profession and enhance our public image. Contact the NCPhA office at 1-800-852-7343 if you can help.

How to Promote NC Pharmacy Week

- Display the "Speak Up America: Talk About Prescriptions" poster in your pharmacy.
- Volunteer to participate in the NC Pharmacy Week phone-in.
- Use the reproduceable fliers in your public relations packets as a bag-stuffer for patients or include it in your mailings.
- Set up a display table emphasizing drug information and promoting NC Pharmacy Week in your hospital cafeteria.
- Volunteer to be a guest speaker at civic organization meetings, e.g., Lions, Rotary, Jaycees, Kiwanis, etc.
- Write a letter to the editor of your local newspaper about medication misuse by older people and in children. Urge senior citizens and parents to visit your pharmacy for more information.
- Invite patients to bring their medications to your pharmacy and discuss them with you.
- Conduct an inservice or seminar for small groups at your church, hospital or pharmacy about the problem of medication misuse and medication compliance.
- Feature a sale on items that help assure medication compliance, such as pill cases.

The NC Pharmacy Week observance is designated as an incentive to communicate with your patients and to inform them of your services and expertise. This is your opportunity to promote the profession of pharmacy.

Let NCPhA know what you are doing to promote NC Pharmacy Week in your pharmacy and community.

PRESIDENT'S REMARKS

Are you into politics? Are you doing your part? There are many of us who have a special opportunity to serve our profession—serving as a lobbyist! This may sound strange to you but you do have an important role to play.

In Washington and Raleigh we have over 200 legislators. Keep in mind that our legislators and their families have prescription needs just like everyone else. Those of us who are serving these families have a golden opportunity to keep them informed about pharmacy issues. We must give them good pharmaceutical services and emphasize the need and the importance of pharmacists in our health care delivery system.

Let the legislators you serve know about your problems such as physician dispensing, freedom of choice, mail order pharmacy, medicaid reimbursement, and discriminatory pricing. I realized how important it is that we have informed legislators, when I recently spent several days with our lobbyist, Virgil McBride, along with our Executive Director, Al Mebane, and others at the Legislative Building in Raleigh. We met with our legislators and spoke to them about increasing our medicaid fee, since we will be losing some 8% off of AWP. At this writing we were successful in getting the House Appropriations Committee to accept a fee of $4.85 which we expect to pass in the Budget.

I also saw that it is imperative for the NCPhA to keep a full-time lobbyist on our payroll. Being in the right place at the right time to answer questions and clarify misinformation is a very important function of our lobbyist. If all of us, however, do our job of keeping the right people informed throughout the year, it becomes a lot easier when we need action taken.

Recently, I spent a day in Washington, D.C. with Bill Mast, Chairman of NCPhA's Third Party Committee, and some of his committee members, Whit Moose and Julian Upchurch. This committee is working on national legislation regarding medicaid reimbursement. During our visit, we talked with representatives of NARD and NACDS. We were well received by both groups. After much discussion, we convinced them to combine their efforts and make the medicaid reimbursement issue a top priority.

The Senate Special Committee on Aging and its chairman, Senator David Pryor, is holding a hearing in Washington on prescription drug prices. They reported prescription prices increased by 88% from 1981-1988, a period during which the Consumer Price Index increased by only 28%. I think we will be hearing and reading a lot from this committee in the future.

Keep yourself informed, keep our legislators informed and stay tuned in! Remember you are needed — be a lobbyist for your profession.

—Ralph H. Ashworth
President, NCPhA

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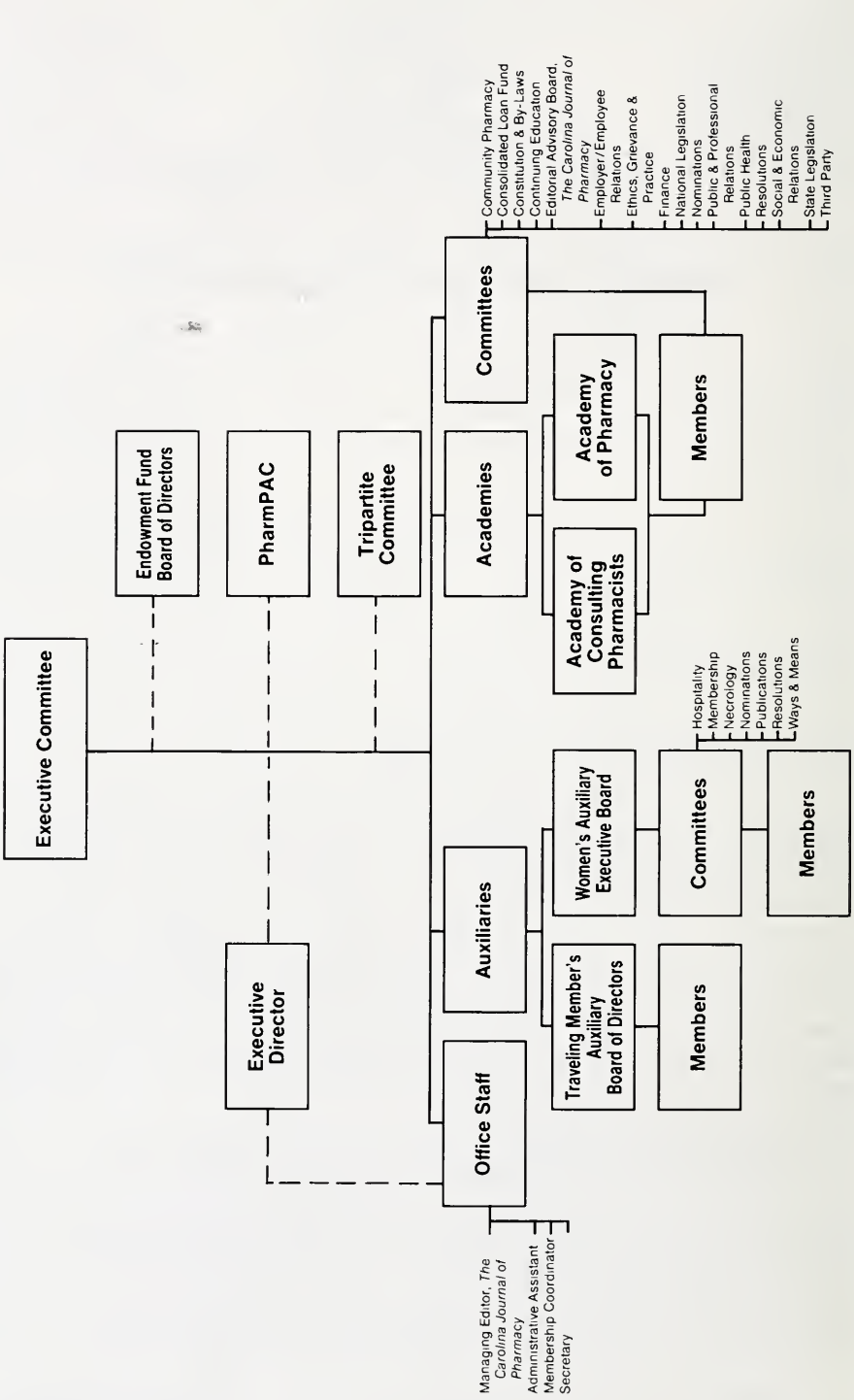

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NCPhA ENDOWMENT FUND IS NOW INCORPORATED

February 20, 1989 marked the day of the newly incorporated Endowment Fund of the NCPhA. On this day, the Secretary of State issued a charter to "The North Carolina Pharmaceutical Association Endowment Fund, Inc." What began as the Building Fund, spearheaded by W.J. Smith and T.J. Ham, Jr. in 1948, has now grown into a multipurpose, corporate endowment fund.

History

Initially, a Building Fund was formed for the purchase of property at 109 Church Street in Chapel Hill and for the construction of an NCPhA-owned office building. From the beginning, NCPhA's Executive Committee decided to maintain such a fund totally separate and apart from the NCPhA budget.

Contributions of nearly $25,000 were raised in the first fund drive, most of which came from $100 payments. The names of the original donors are listed on a bronze memorial plaque hanging in the front lobby of NCPhA's headquarters, the Institute of Pharmacy.

Since the completion of the Institute of Pharmacy in 1951, funds have been solicited, periodically, for improvements, repairs and general maintenance of the physical facilities. Along the way, the name was changed from the Building Fund to what is now called the Endowment Fund.

In 1986, NCPhA President, Keith Fearing, appointed a Finance Committee with L. Milton Whaley as Chairman. Under the leadership of Mr. Whaley, the Finance Committee discovered that no formal document existed for the Endowment Fund. The Committee suggested that a document formally establishing the Endowment Fund be written. L. Milton Whaley was appointed to prepare the document which was later approved by NCPhA's Executive Committee in the spring of 1987.

The 1986-87 Executive Committee also approved an annual fund raising dinner for the Endowment Fund. The First Annual Endowment Fund Dinner took place at the Kenan Center in October 1987. Contributions in excess of $22,000 were received. An additional $12,825 in donations were obtained the following year for the annual fund raiser.

Through the years, significant contributions to the fund have been made by individuals and administered as designated funds according to the wishes of the donors. Thus, the assets which comprise the Endowment Fund today are used for a variety of purposes.

Earlier this year, the 1988-89 Executive Committee explored the advantages and benefits of incorporating the Endowment Fund into a separate, non-profit, tax-exempt entity. After reviewing other possible options, the Committee decided that incorporating the Endowment Fund was in the best interest of NCPhA and Fund donors.

Purpose

The purpose of the newly incorporated Endowment Fund has been redefined as stated in the Certificate of Incorporation and By-Laws, Article I. It is:

- To foster and maintain the honor and integrity of the pharmaceutical profession.
- To provide for the Administration and Investment of designated funds (currently in the funds or any new designated funds to be added in the future) for charitable, scientific, literary or educational purposes as directed by the donor.
- To provide for the administration, investment and appropriation of budget requests of the general endowment fund for charitable, scientific, literary or educational purposes.
- To promote and elevate the standards of pharmaceutical education; provided that no substantial part of its activities shall involve the carrying on of propaganda or otherwise attempting to influence legislation.
- To provide income to the North Carolina Pharmaceutical Association to aid in achieving charitable, scientific, literary or educational goals.

Board of Directors

An initial Board of Directors consisting of 3 members was established until an expanded 10-member Board could be organized by the NCPhA president. Robert B. Hall of Mocksville, Howard Q. Ferguson of Randleman, and L. Milton Whaley of Durham formed the initial Board.

According to Article V, Section 2 of the Corporation's By-Laws, 4 of the 10 members shall be ex-officio members and shall be those individuals holding the following NCPhA offices: president, president-elect, immediate past president and the Executive Director. The President of NCPhA will be entitled to appoint the remaining six at-large directors. Initially, 2 directors will be appointed for a one year term, 2 for a 2 year term, and 2 for a 3 year term. Thereafter, 2 directors will be appointed each year for a 3 year term.

Continued on page 18

THE LOWER RESPIRATORY TRACT—
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Summary.
Consult the package literature for prescribing information.
Indication: Lower respiratory infections including pneumonia, caused by *Streptococcus pneumoniae, Haemophilus influenzae,* and *Streptococcus pyogenes* (group A β-hemolytic streptococci)
Contraindication: Known allergy to cephalosporins
Warnings: CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.
Administer cautiously to allergic patients.
Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.
Precautions:
• Discontinue Ceclor in the event of allergic reactions to it.
• Prolonged use may result in overgrowth of nonsusceptible organisms.
• Positive direct Coombs' tests have been reported during treatment with cephalosporins.
• Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
• Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
• Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.
Adverse Reactions: (percentage of patients)
Therapy-related adverse reactions are uncommon. Those reported include:
• Gastrointestinal (mostly diarrhea) 2.5%
• Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
• Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, and serum-sickness-like reactions that have included erythema multiforme [rarely, Stevens-Johnson syndrome] and toxic epidermal necrolysis or the above skin manifestations accompanied by arthritis/arthralgia, and frequently, fever) 1.5%, usually subside within a few days after cessation of therapy. Serum-sickness-like reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.
• Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
• As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
• Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.
• Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%; and, rarely, thrombocytopenia.
Abnormalities in laboratory results of uncertain etiology:
• Slight elevations in hepatic enzymes.
• Transient fluctuations in leukocyte count (especially in infants and children).
• Abnormal urinalysis, elevations in BUN or serum creatinine.
• Positive direct Coombs' test.
• False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clinitest® tablets but not with Tes-Tape® (glucose enzymatic test strip, Lilly).
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PharmaDates

1989

October 5—Woman's Auxiliary Fall Convocation, Institute of Pharmacy

October 8—Upjohn Grant Committee Meeting, Institute of Pharmacy

October 8-14—NC PHARMACY WEEK

October 11-15—Pharmacy in the 21st Century Invitational Conference, Williamsburg, VA

October 16—Board of Pharmacy Reciprocity Examination, Institute of Pharmacy

October 16—Tripartite Committee Meeting, Institute of Pharmacy

October 17—Board of Pharmacy Meeting, Board of Pharmacy

October 21—Endowment Fund Dinner, Kenan Center, Chapel Hill

November 11-15—NARD 91st Annual Convention, San Antonio, TX

November 20—Board of Pharmacy Reciprocity Examination, Institute of Pharmacy

November 21—Board of Pharmacy Meeting, Board of Pharmacy

December 3-7—ASHP Midyear Clinical Meeting, Atlanta, GA

1990

March 10-14—APhA Annual Convention, Washington, D.C.

March 22—NCPhA Socio-Economic Seminar, High Point

May 23-26—NCPhA Annual Convention

June 2-6—ASHP Annual Meeting, San Diego, CA

October 20-25—NARD Annual Meeting, Nashville, TN

ENDOWMENT FUND

Continued from page 15

The following Board of Directors was appointed prior to NCPhA's Annual Meeting:

L. Milton Whaley, President ..... Durham *(3 years)*
Keith Fearing, Vice President ..... Manteo *(2 years)*
A.H. Mebane, Secretary-Treasurer ..... Chapel Hill
Marshall Sasser ..... Smithfield *(1 year)*
Frances Rader Lena .. Dallas, TX *(2 years)*
Robert B. Hall ..... Mocksville *(1 year)*
Howard Q. Ferguson ..... Randleman *(3 years)*
Julian Upchurch ..... Durham
Ralph Ashworth ..... Cary
Albert Lockamy ..... Raleigh

Officers of the Corporation shall consist of a President, Vice President, a Secretary, and a Treasurer. (Article I, Section 1.) They will be elected annually by the Board from its membership at its regular annual meeting following the annual Endowment Fund Dinner. (Article VI, Section 2.)

Members of the Corporation shall be individuals who have contributed $1,000 or more to the Endowment Fund and are members of NCPhA or by approval of the Board of Directors. (Article III, Section 1.) *Sustaining Members* are individuals who make a contribution to the Endowment Fund and are members of NCPhA or by approval of the Board of Directors. Sustaining Members will be recognized as Members when their total contribution reaches $1,000. (Article III, Section 2.) To date, 17 Members and 67 Sustaining Members comprise the total membership of the Endowment Fund.

Board Responsibilities

The affairs of the Corporation shall be managed by its Board of Directors. (Article V, Section 1.) This includes the administration and investment of designated funds for charitable, scientific, literary or educational purposes and to appropriate budget requests.

Each Member or Sustaining Member shall be entitled to one vote on each matter submitted to a vote of the membership. (Article III, Section 3.)

Current Assets

The current assets of the NCPhA Endowment Fund as of December 31, 1988 are:

Current Assets	
General Endowment Fund	$155,953.79
Ralph P. Rogers, Sr. Scholarship Fund	18,605.64
J.S. Stewart Scholarship Fund ...	8,627.83
W.J. Smith Speaker Fund	5,181.01
Total	$188,368.27

In April 1989, a new scholarship fund was established in the name of Ralph P. Rogers, Jr., the recently retired Executive Vice President and Chief Executive Officer of NC Mutual Wholesale Drug Company by friends and members of NC Mutual. This new donation boosted the Endowment Fund by more than $80,000. (Note: A minimum of $5,000 is needed to establish a new designated fund. [Article VIII, Section 2.])

1989 Endowment Fund Dinner

Plans are currently underway for this year's annual fund raiser. A dinner and program will be held on October 21, 1989 at the Kenan Center in Chapel Hill with Irving Rubin, Editor-at-Large of *Pharmacy Times* as featured speaker. Place this date on your calendar now and look for details of this important affair in upcoming issues of the Journal.

Acknowledgement

I would like to thank Milton Whaley for his patience and assistance in the preparation of this article. Thanks to his financial savvy and countless hours of devotion, the Endowment Fund is now a more valuable asset for the Association and its beneficiaries. Annual Reports for his term as immediate past Chairman of the Finance Committee and Endowment Fund appeared in the July issue of *The Carolina Journal of Pharmacy.* Please join me in thanking him for a job well done!—*Kathryn Jefferson, R.Ph., Managing Editor, The Carolina Journal of Pharmacy*

STATE BOARD OF PHARMACY

Members — W. R. Adams, Jr., Wilson; Harold V. Day, Spruce Pine; W. Whitaker Moose, Mount Pleasant; W. H. Randall, Lillington; Jack G. Watts, Burlington; William T. Biggers, Asheville; David R. Work, Executive Director, P.O. Box H, Carrboro, NC 27510.

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NEWLY LICENSED PHARMACISTS

CONGRATULATIONS to the 149 pharmacists recently licensed by passing the Board of Pharmacy examinations in June. We welcome them into the profession and wish them much success and fulfillment.

Licensed By Examination

Adams, Joy Renee, Elizabethtown, NC
Adams, Kimberly Dawn, Asheville, NC
Adcock, Emily Maureen, Wilmington, NC
Averitt, Phillip Louis, Greensboro, NC
Barnes, Lisa Annette, Selma, NC
Barnett, Joe Robert, Jr., Maysville, NC
Beach, Trent Allen, Chapel Hill, NC
Benton, Leigh Ann, Pikeville, NC
Bishop, Vicky Faye, Raleigh, NC
Blanchard, Judy Ezzell, Burgaw, NC
Brady, Mary Susan, Greensboro, NC
Bray, Angela Dawn, Charlotte, NC
Bray, Bryan Keith, High Point, NC
Britt, Susan Elizabeth, Fairmont, NC
Brogden, Harry Lee, Jr., Charlotte, NC
Brown, Laura Elizabeth Hundley, Winston-Salem, NC
Brown, Sharon Denise, Greenville, NC
Bryant, Jennifer Smith, Gastonia, NC
Buchanan, Margaret McLarty, Hight Point, NC
Bullard. James Samuel, Lillington, NC
Bunn, Debra Lynn, Wilson, NC
Burkot, Barbra Beth, Elm City, NC
Cardwell, Phillis Chance, Charlotte, NC
Cartrette, Matthew Charles, Chadbourn, NC
Castelloe, Kellena Dawn, Fayetteville, NC
Cates, Philip Burrell, Jr., Charlotte, NC
Clayton, Jerry D'Wayne, Chapel Hill, NC
Clifton, Barbara Eloise, Faison, NC
Cloninger, Byron Mark, Hickory, NC
Cody, David Emmett, III, Hickory, NC
Corrigan, Pamela Ann, High Point, NC
Courtney, Angela Michelle, Rocky Mount, NC
Cox, Myra Susan, Ramseur, NC
Crisp, Dorothy Lucinda, Greensboro, NC
Crocker, Richard Everett, Farmville, NC
Crook, Rebecca Norma, Wilson, NC
Davies, Jill Alyssa, Chapel Hill, NC
Davis, Dawn Renee, Cameron, NC
Davis, Ouita Renee, Raleigh, NC
Davis, Steven Michael, Winston-Salem, NC
Dawson, Wilson Lyle, Miami, FL
Dickerson, Regina Gray, Hamptonville, NC
Dillard, Russell Franklin, Rocky Mount, NC
Dixon, Carol Lynn, Fayetteville, NC
Duncan, Pamela Jean, Chadbourn, NC
Dunn, Jackie Michele, Charlotte, NC
Efird, Judy Morris, Wilmington, NC
Elkins, Gregory Lee, Clarkton, NC
Evans, John Roland, Wilmington, NC
Fairly, Milton McIntyre, III, Greensboro, NC
Furman, Theresa Marie, Cary, NC
Gallagher, Andrea Joy, Marion, NC
Gilbert, Tammy Stewart, Durham, NC
Gothard, Evan Elliott, Durham, NC
Greenwell, Mark Damian, Jacksonville, NC
Guy, William Preston, Gastonia, NC
Harper, Angela Camille, Durham, NC
Harvey, Lisa Anne, Raleigh, NC
Hefter, Cori Christine, Cary, NC
Hobbs, Anita Marie, Conover, NC
Hoggard, Timothy Griffin, Micanopy, FL
Holbrook, Layna Sue, Kernersville, NC
Hungerford, Teresa Ann, Charlotte, NC
James, Mamie Catherine, Carrboro, NC
Jeffreys, Nelda Leigh, Zebulon, NC
Johnson, Rhonda Lanette, Broadway, NC
Jones, Christopher Michael, Dudley, NC
Kearns, Lynne Karen, Chapel Hill, NC
King, Beth Smith, Seagrove, NC
Kochanowicz, Susan Elizabeth, Carrboro, NC

Continued on page 21

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BOARD OF PHARMACY

Continued from page 19

Kothapalli, Venkata Markandeya, Wilson, NC
Langley, Karen Wendell, Burlington, NC
Le, Tam Phuong, NC
Lee, Byron Dale, Jacksonville, NC
Lee, Jeffrey Todd, Carrboro, NC
Linn, David Alan, Kannapolis, NC
Liverman, Karen Deneen, Greensboro, NC
Lofland, Lucy Bly, Newton, NC
Loper, Daniel Clark, Athens, GA
Lucey, Ellen Marie, Greenville, NC
Lynds, Jeffrey Everett, Charlotte, NC
Lynn, Mary Page, Petersburg, VA
Markham, Tammy Lynn, Charlotte, NC
Marshall, Cynthia Diane, Greensboro, NC
Martin, Meritza Rebecca, Durham, NC
May, Donald Byron, Durham, NC
Mayo, Katie Elizabeth, Fayetteville, NC
McCauley, Mark Steven, Greensboro, NC
McCauley, Vincent Allen, Carrboro, NC
McFarland, Lisa Jean, Charlotte, NC
McLemore Libby Dale, NC
Michalove, Louis Rolland, Asheville, NC
Millard, Shelly Smith, Durham, NC
Miller, David Farrel, Salisbury, NC
Miller, Jonathan Andrew, Fayetteville, NC
Miller, Kevin Lynn, Waynesville, NC
Mitchem, Maria Lynn, Raleigh, NC
Moore, Teresa Helen, Salisbury, NC
Morris, Gregory Alan, Forest City, NC
Moss, Stephen Wayne, NC
Murrow, Lucretia Faye, NC
Myers, Andrew Michael, Goldsboro, NC
Newkirk, Kimberly Ann, Carrboro, NC
Nunn, Susan Michelle, Concord, NC
O'Quinn, Stephen Venson, Durham, NC
Owen, Kimberly Marie, Carrboro, NC
Owens, Elizabeth Ann, Charlotte, NC
Padgett, Alan Mack, Durham, NC
Pippin, Herbert Joel, Jr., Chapel Hill, NC
Pope, Melanie Walters, Hillsborough, NC
Powell, Jill Lalee, Charlotte, NC
Powers, Sandra Ann, Cary, NC
Preast, Dwayne Clark, NC
Prescott, Ruth Annette, Greensboro, NC
Progelhof, Linda Ann, Columbia, SC
Register, Cynthia Dawn, Wilmington, NC
Robertson, James Douglas, NC
Robertson, Robbin Renee, Greensboro, NC
Roten, John Wilson, SC
Rouse, Wendy Leigh, Kinston, NC
Rowland, Kimberly Dawn, Kannapolis, NC
Sarver, Pamela Jean, Chapel Hill, NC
Share, Michael James, Winston-Salem, NC
Sharma, Venita Kamla, Raleigh, NC
Sills, Tammy Renea, Charlotte, NC
Slater, Amy Jo, Raleigh, NC
Smart, Jennifer Margaret, Greenville, NC
Smith, Alice Elizabeth, Morehead City, NC
Spivey, Luisa Andrade, Raleigh, NC
Stageberg, Cynthia Glass, Charlotte, NC
Stolpa, Michelle Ellen, Charlotte, NC
Tallent, Timothy Elton, Franklin, NC
Tauscher, Nan Virginia, Charlotte, NC
Thompson, Lori Elizabeth, Lucama, NC
Thompson, Michael Edward, Hope Mills, NC
Trunk, Suzanne Marie, Rocky Mount, NC
Tsamutalis, Elefteria Chrisanthi, Burlington, NC
Tunstall, Susan Krisan, Garner, NC
Urquhart, Betsey Derr, Ahoskie, NC
Vecchiolla, James Arthur, Gastonia, NC
Waldrop, Daryl Manning, Horse Shoe, NC
Watkins, James Nathaniel, Jr., Durham, NC
White, Karen Sue, Asheville, NC
Whitehead, Paula Jean, Wilson, NC
Williams, Charlotte, NC
Windley, Gina Mangas, Chapel Hill, NC
Wolff, Stefani Ann, Daytona Beach, FL
Womack, Angela Caroline, Chapel Hill, NC
Young, Karen Leigh, Durham, NC

Welcome, New Members!

The following persons have joined NCPhA since the publication of our last journal issue. We are glad these pharmacists have joined their colleagues in the Association who are committed to preserving the future of pharmacy practice in North Carolina.

Angela Harper, Durham
Tim Kurek, Morrisville
Emily Traywick, Charlotte
Jerome Turchin, Mt. Carbon, WV
Bob L. Brown, Raleigh
Gina Mangas Windley, Chapel Hill
Terri B. Cardwell, Eden
Myra Cox, Ramseur
Ellen M. Lucey, Greenville
Elaine J. Disney, Garner
Teresa Dunsworth, Chapel Hill
Sidney B. Johnson, Carthage
Byron D. Lee, Jacksonville
Ouita Davis, Raleigh
Joy D. Thomas, Charleston, SC
Deborah L. Hightower, Charlotte

The guest of honor, Ralph P. Rogers Jr., gives a heartfelt thanks to his audience, recognizing all who supported him throughout his career.

Don Peterson, the new Executive Vice President and CEO of NC Mutual Wholesale Drug Co., and his wife, Dixie.

Photos by Qualex-Colorcraft

A TRIBUTE TO RALPH P. ROGERS JR., A LEADER IN THE WHOLESALE DRUG INDUSTRY

A special evening honoring Ralph Peele Rogers Jr. on his retirement from NC Mutual Wholesale Drug Company took place on April 22, 1989. A multitude of family, friends and business associates attended a reception and dinner at the Omni Europa Hotel in Chapel Hill.

Banks D. Kerr, President of Mutual's Board of Directors, served as the master of ceremonies for the evening program following dinner. Program participants included Louis Shields, former Board member of Mutual Drug Co. for 30 years, now a retired pharmacist, Jacksonville, NC, Charles Trefrey, President of the National Wholesale Druggists' Association, Washington, D.C., Terry George, Manager, Customer Relations, Burroughs Wellcome, Greenville, NC, and Lawrence DuBow, former owner of Lawrence Pharmaceuticals, Jacksonville, FL. All acclaimed Ralph for his contributions to the wholesale drug industry and to his community.

Speakers Pay Tribute

Mr. Shields traced Ralph's distinguished pharmacy career to the days when he began in 1949 as a community pharmacist in Durham at Rogers Drug Company. In 1962, the untimely death of NC Mutual Wholesale Drug Co.'s General Manager, D.L. Boone Jr., brought Ralph to the company's forefront. He took over as General Manager and spent the next 26 years of his pharmacy career at NC Mutual. Shields attributed much of the company's success to Ralph's leadership, vision, and perseverance. During the early 60's, Ralph's vision prompted the company to install an elaborate, state-of-the-art conveyor system to facilitate rapid order filling and shipping. He continued to add many unique services over the years such as, a training program for retail store personnel, a computerized data processing system in 1967, and an inventory tracking system in 1981.

Charles Trefrey shared an inspirational article entitled, "The Law of the Shadow" written by Bishop Ernest A. Fitzgerald, resident bishop of the Atlanta area United Methodist Church and a native North Carolinian. "The central theme of the article," Mr. Trefrey explained, "was that few of us achieve great heights on our own. Most of us can point to a teacher, a relative, a counselor, or a coach who came into our lives and made a significant difference. There is always someone who spreads over us a shadow of direction and inspiration. Ralph Rogers Jr. has been such a person for me and many of us." Mr. Trefrey further explained the tremendous impact Ralph had onevents and developments in drug wholesaling and drug retailing during the past two decades at the national and North American level. As president of the Federal Wholesale Druggists' Association, he helped direct these organizations and influence policy in the wholesale drug industry.

Terry George, having known Ralph for 22 years, couldn't resist the opportunity to "roast" him even though he was given strict instructions by the master of ceremonies not to do so. "That's like telling someone not to put their finger on a sign that says, 'WET PAINT'," George retorted, and so he proceeded. (Ralph's wife, Lib, was not spared either, of course.) His humorous stories and anecdotes about Ralph delighted the audience. On a more serious note, however, George ended with a quote by Thomas Jefferson to describe the life and philosophy of Ralph Rogers: "To do our fellow man the most good in our power we must lead them, follow where we cannot and still go with them, watching always the favorable moment for helping them to another step."

Lawrence DuBow applauded Ralph "for giving more life and lift to the drug industry" than any man known to him. DuBow cited a quote by Vince Lombardi: "Winning isn't everything—it's the only thing." "Unlike the game of football," DuBow explained, "where you have to knock the other fellow down, in the game of life, you have to lift the other fellow up, which is what Ralph did so well."

Career Highlights

Ralph spent 26 years with NC Mutual, first, as General Manager, and later, as Executive Vice President and Chief Executive Officer until he retired on August 31, 1988. Over the years, Ralph witnessed many changes in the company. When he started in 1962, Mutual had 140 members and an annual sales volume of $4 million. By 1988 the company had grown to 412 members and posted annual sales of $131 million. Mutual's distribution center also grew in size when new additions were constructed in 1967, 1971, 1975 and 1987.

In addition to his loyal service to Mutual Drug Company, Ralph contributed much of his time and energy to the profession of pharmacy in North Carolina. As a member of the North Carolina Pharmaceutical Association, he was involved in many Association activities. He was active on various Association committees, a member of the

Continued on page 25

GEER

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RALPH P. ROGERS JR.

Continued from page 23

NC Academy of Pharmacy, a previous A.H. Robins Bowl of Hygeia Award recipient and the 1980 Pharmacist of the Year. Ralph was a member of the Durham-Orange County Pharmaceutical Association and served on the North Carolina Pharmaceutical Research Foundation and the Pharmacy Foundation of North Carolina.

He was also involved in many civic activities as Chairman of the Durham County Mental Health Advisory Committee, a Gubernatorial Appointee to the Research Triangle Planning Commission, Chairman of the Durham County Board of Health, Director of Security Federal Savings & Loan Association of Durham, Director of the Foundation for Better Health of Durham, and Area Board Member for the Durham County Mental Health Center. In 1960, he was named Durham Young Man of the Year.

The Ralph P. Rogers Jr. Scholarship Fund

To recognize Ralph's contribution to pharmacy and to the drug industry, Mutual Drug Company decided to endow a scholarship fund in his name. A committee was created to organize The Ralph P. Rogers Jr. Scholarship Fund. To help make this possible, a fund raising dinner was planned. As a result, a $100 a plate dinner combined with many generous donations generated a total amount of over $80,000. (The reception and dinner for the evening were underwritten by Burroughs Wellcome and Glaxo, Inc., respectively, so that all donations could go directly to the scholarship fund. Other costs were covered by friends of Ralph.)

On behalf of the NCPhA, Ralph H. Ashworth, president of the NCPhA, accepted a check for the Ralph P. Rogers Jr. Scholarship Fund. The monies have been placed in a designated fund in the NCPhA Endowment Fund. The newly established fund represents one of the largest individual funds administered by the Endowment Fund Board of Directors.

Fund Raising Committee

Much of the success of the fund raiser can be attributed to the Ralph P. Rogers Jr. Scholarship Fund Committee:

John Robert Bowers
Bethel Pharmacy
Thomas Peete Davis
Yanceyville Drug
Banks D. Kerr
Kerr Drug Stores
William Whitaker Moose
Moose Drug Company
Jack F. Munroe
Burroughs Wellcome Co.
Charles Michael Whitehead
R & M Mutual Discount Drugs
Donald Vance Peterson
NC Mutual Wholesale Drug Co.
Darleen G. Smith
NC Mutual Wholesale Drug Co.

Without the hard work, dedication and organization of these individuals, the success of this undertaking would not have been possible.

A Special Touch

Portraits of Ralph and Lib, gifts from NC Mutual, were unveiled at the close of the evening tribute to Ralph. Another portrait of Ralph was designated as a permanent display for the lobby of NC Mutual's home office.

Your Contribution

If you would like to contribute to the Ralph P. Rogers Jr. Scholarship Fund, you may make your check payable to the NCPhA Endowment Fund and mark it for The Ralph P. Rogers Jr. Scholarship. All donations to the scholarship fund are 100% tax deductible. Mail your check to: NCPhA, P.O. Box 151, Chapel Hill, NC 27514.

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REPORT OF THE ELECTIONS COMMITTEE

The Elections Committee of the North Carolina Pharmaceutical Association met today, August 10, 1989, at the Institute of Pharmacy in Chapel Hill to open and tally the mail ballots for NCPhA offices and the Pharmacy Foundation of North Carolina Board of Directors.

The NCPhA officers elected will be installed at the 1990 Annual Convention to be held in Durham in May and will serve for the 1990-1991 Association year. Betty Dennis will serve as 1990-91 President Elect and as the first female President of the North Carolina Pharmaceutical Association for the 1991-1992 Association year.

The results are:

For NCPhA First Vice President
(President Elect) *Betty H. Dennis,* Carrboro

For NCPhA Second Vice President
Joey Edwards, Raleigh

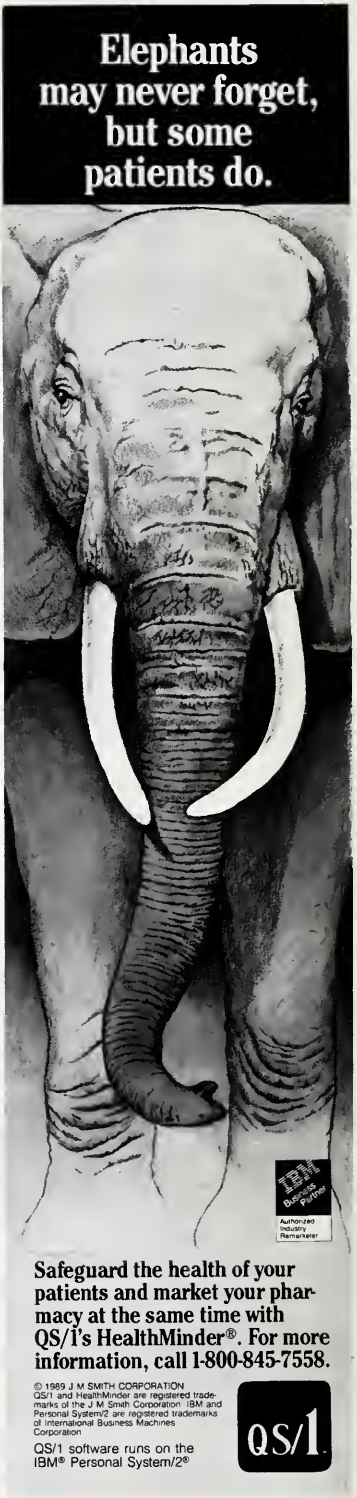
For NCPhA Third Vice President
Henry L. Smith, Farmville

For NCPhA Executive Committee
(One year terms)
W. Robert Bizzell, Kinston
Sarah Beale Cobb,
Southern Pines
Robert Worley, Princeton

For Board of Directors of the Pharmacy Foundation of North Carolina, Inc.
Laura Burnham,
Winston-Salem
Robert Hall, Mocksville
John Hood, Kinston
Milton Whaley, Durham

The Elections Committee hereby declares the above listed persons as having been duly elected to be installed according to the Constitutions and By-Laws of the organizations to which they belong.

Respectfully submitted,
The Elections Committee
E.A. Brecht
Lee Werley
Linda Butler
Mel Chambers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Individual Creativity Among Professionals

This is the eighth in a series of articles for professionals who manage and managers who lead professionals and those who are both. Pharmacists operate with one license, but fill many different professional roles in hospitals, chain stores, individual stores, drug companies and universities. Along the way they need a broad variety of management skills. These articles take a broad perspective on management concepts we hope you will be comfortable applying.

Curtis P. McLaughlin

We say we want creativity, but then we don't know what to do with it when our people show it. My Sri Lankan colleague illustrates this with a story. At a fine English preparatory school there was a young student who was known to be unusually intelligent and creative, but somewhat eccentric. On a physics examination he was asked to answer the question "How would you measure the height of a tall building using a barometer." His answer was "Which method do you want, there are many many ways to do it." The examiners were taken back by this and called the student in. They repeated the question and he repeated his answer. They asked him to give a specific answer. "Well, one way is to take the barometer up to the top of the building and drop it off the roof and measure how long it takes to hit the ground. Then you would be able to calculate the height." "No. Give us another one," the examiners asked. "All right. At about 10 a.m. I would measure the shadow of the building. Then I would measure the length of the barometer, hold it straight up on the ground and measure its shadow. The ratio of the two shadows would be the same as the ratio of the length of the barometer to the height of the building," the boy responded. "No," said the examiners, "that is not what we were looking for. Give us another." The boy was irritated, but he responded. "All right, I would walk up the stairs of the building marking off lengths of the barometer along the stairwell walls. Then I would count the marks on my way down and multiply that number times the length of the barometer." Now the examiners were exasperated. They rejected that answer. "That is not what we are looking for. You cannot use any measuring tool besides the barometer." The boy thought a few minutes and then smiled. "All right. I would go find the apartment of the building superintendent, bang on his door with the barometer, and, when he answers, say 'Mr. Super. I will give you this shiny new barometer if you will tell me the height of this building.' "

Creative people will not see things the way that you expect them to. Management has to find ways to encourage them to work effectively within the organization without stifling their creativity. They must be provided with a setting which tolerates their non-conformity in both thought and behavior working individually and in groups. The attributes of such an organization include:

- –Open channels of communication
- –Many contacts with the outside world
- –Ideas judged on their merits and not on the status of provider
- –Ideas are tested rather than prejudged
- –Professional autonomy is allowed
- –Celebration and fun are encouraged
- –Risk taking is not punished.

Continued on page 28

CURTIS P. MCLAUGHLIN is a Professor of Business Administration in the School of Business and Professor of Health Policy and Administration in the School of Public Health at the University of North Carolina at Chapel Hill. McLaughlin received his masters and doctorate degrees in Business Administration from Harvard Business School. He has written numerous management articles for a variety of publications, including Harvard Business Review, and has consulted for domestic and international corporations. Some of his professional interests include the production of professional services in research, engineering, medicine, public health and education; management of not-for-profit organizations; and productivity improvement.

INDIVIDUAL CREATIVITY

Continued from page 27

Communication

Creativity is the coming together of ideas that don't come together normally. The creative individual recombines concepts and cues to come up with something that most of us would not think of. Creative insight is often described as things clicking or falling into place. It is a mixture of perspiration and inspiration. The more ideas that one processes, the more likely that interaction. Different creative people operate with different processes. Some consciously turn the problem over to their subconscious brain and ignore it until something spills out. Others make lists of ideas and gradually narrow them down, making associations from the lists. Some brainstorm among themselves. Others go out and talk to lots of people and gather lots of stimuli until the analogies pop out at them. Each of these processes for managing creativity has in common the facilitation of a high level of communication inside and outside the organization.

Gatekeepers

The existing research on effective research and development emphasizes the role of key individuals in the organization through whom most information naturally flows. There are such key informants in every information-seeking group. They are referred to in the literature as gatekeepers or information stars. These people, usually a very small percentage of the staff, are at the hub of most of the technical information flows. When one needs information, one doesn't just go through everything in the library. One goes to the people and places that have already sifted through it, that either are the experts or, more likely, know how to contact the experts. Most of that communication is face-to-face. I have just finished studying the behavior of people who make policy about scientific and technical matters in industry and government, including the FDA and major pharmaceutical companies. In the majority of cases the search for information starts with a face-to-face encounter or a phone call. That reality hasn't changed in twenty-five years of conducting such research.

Gatekeepers serve those who are less extroverted, less far-ranging in their searches, less active professionally. The problem is that information stars (the word gatekeeper implies restriction to some) are born, not made, and they are seldom rewarded by the organization for performing that function. Sometimes they are even put down as dilettantes or as unfocused or as unattentive to their primary assignments. Yet they are a key to research productivity and creativity. Pay attention to the care and feeding of gatekeepers.

One of my most creative colleagues uses the method of processing as much information as possible to create new ideas. His office is stacked waist-high with documents that he scans and sets in piles. It drives our secretary, a self-confessed "neat freak," up the wall. A guest has to clamber around piles to get into the only open spot, an old armchair, to have a conversation. Last summer my wife and I were at a store in Nags Head, NC and I saw a bumper sticker that said, "Neat people never make the exciting kinds of discoveries I do." I bought it and uninvited put it on his office door. He has left it there because we both understand that that expresses a conscious style on his part.

Openness to New Ideas

Staying open to information and then to ideas is key to creativity. It is seldom universal. A given individual will be open to some types of ideas and closed to others. Their closedness is often in areas closest to their professional egos. People who have been creative in the past can get stuck by their successes. Priestly, the discoverer of oxygen, went to his deathbed believing in the phlogiston theory. Even though his discovery was behind that new interpretation of nature, he could not assimilate it. Management must do all it can to maintain a culture of openness to new ideas.

The place to start is with management supporting and behaving according to the principle that any one person's ideas are as good as anyone else's. Management must be willing to listen regardless of the status of the person with the idea. They must be willing to test ideas rather than dismissing them out of hand. Managers must be willing to listen to ideas and respond promptly to suggestions.

In my own research on the movement of new products to market in electronic instrument firms in four developed countries this factor which we called absence of status consciousness was closely related to speed in getting the products through development and into production.[1] Such research repeatedly shows the major impact of organizational climate on the productivity of creative professionals.

Work Has To Be Fun

We have often thought of play as creative and work as not. If it seems like work, it may not be creative. Successful, creative organizations allow

a lot of play. Professionals are encouraged to get excited about their work. They interact with lots of interesting people. They are doing something that is significant. Group cohesiveness is built around positive experiences, not around conformity nor a seige mentality. Successes are celebrated so that others can see that effort and creativity pays off.

Risk-taking Is Encouraged

Creativity will not occur without a lot of wild goose chases and failures. If people are prejudged and/or second guessed, they soon lose their creativity. They must be encouraged to take more risks than normal intellectually if they are to be creative. Creativity is a very fragile quality, especially among the young.

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[1]S. Bergen and C.P. McLaughlin, "The R&D/Manufacturing Interface in Four Developed Countries," *International J. of Operations and Production Management*, 8:7, 1988, pp. 5-13.

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Continued on page 32

CLASSIFIED

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L. Milton Whaley, 1989 Pharmacist-of-the-Year with his wife, Neta. *Photo by Qualex-Colorcraft*

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PRESIDENT'S MESSAGE

On Sunday, September 10, 1989, your Executive Committee met in Chapel Hill and took action on a recommendation from the Finance Committee. After reviewing our financial situation, we have decided we must raise our active dues to one hundred dollars per year, effective January 1, 1990. Our dues have not changed in five years and you know from your own personal and business expenses that the cost of almost everything has escalated during this period. Our postage bill alone is over $30,000 annually, and our building has increased in value, resulting in higher taxes. With the addition of a part-time lobbyist, Virgil McBride) and part-time staff member (Kathryn Jefferson, Managing Editor of the *Carolina Journal of Pharmacy*) the normal salary increases, and a host of other items—you can understand why we have a shortfall in funds needed to meet our budget. By way of comparison, neighboring states' dues are: Georgia –$225.00, Florida – $225.00, Virginia – $100.00, and South Carolina – $99.00.

We hope all of our members (approx. 2600) will understand the need for this action. I would like to remind you that a Life Membership is 10 times the yearly dues. If you select this membership for 1990 and pay before December 31, 1989, the cost is $750.00. After January 1, Life Membership dues are $1000.00. The revenue from Life Memberships is deposited in a special fund and your Association uses only the interest generated by the fund each year. Therefore, you can see that your contribution as a Life Member is everlasting.

Being a member of your pharmaceutical association makes a positive statement about you and your profession. It is seldom that an individual, working alone on any project can make the impact that a large organized group can make—whether it is in celebrating Pharmacy Week, dealing with the Legislature on pharmacy issues, or dealing with anything pertaining to safeguarding the public health of our citizens. Sometimes we do hear members say, "But what are you doing for me?" To them, let me paraphrase the late President John F. Kennedy and say, "It is not what Pharmacy can do for me, but what I can do for Pharmacy."

We encourage our new pharmacy graduates to join our Association. Therefore we are offering dues for the first full year of only $25.00 This must be taken advantage of within three months of graduation. Recently I carried greetings from our NCPhA to the Pharmacy School of Campbell University at its Fall Convocation, and conveyed congratulations for their record of 100% membership in the student branch of NCPhA. Upon graduation we are expecting a large number to join our Association—as well as those graduates of UNC School of Pharmacy.

Your Executive Committee also voted to encourage the Constitution and Bylaws Committee to develop the classification of Associate Membership, to be presented to the membership. The dues would be the same as active membership dues. This classification would accomodate those not eligible for active membership and would carry all rights and privileges, except voting and holding office.

Our annual Convention has been moved to the Sheraton Imperial on I-40 in Durham. The dates will be May 23 through May 26 and Steve Dedrick of Durham will be our Convention Chairman. Plans are still being formulated for a post-convention trip and you will receive a mailing soon.

Your Association is an active and viable organization. It is counting on you. If you have questions about these matters, call Al Mebane at the Institute of Pharmacy at 1-800-852-7343 or me at (919)467-1877.

NCPhA President
Ralph H. Ashworth

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Linda Progelhof, Charlotte
Stefani Wolff, Daytona Beach, FL
Karen L. Young, Durham
James M. Davison, Toledo OH
Becky Crook, Wilson
Renne S. Covington, Haw River
Toby Hoffman, Chapel Hill
Cathe James, Carrboro
Donna K. Saufley, Tallahassee, FL
Marjorie Tompkins, Raleigh
Ann R. Edwards, Nebo
Stan Haywood, Asheboro
Russell F. Lovell, Tamarac FL
Mitchell Marsh, Goldsboro
Cindy Register, Wilmington
William Cowden, Pfafftown
Cynthia D. Marshall, Greensboro
*Judy Blanchard, Burgaw
Grace Hafner, Durham
Mark Kothapalli, Wilson
Robin C. Meade, Taylorsville
Mark C. Kesler, Wilmington
Harry Lee Brogden Jr., Charlotte

* Indicates **Life Member**

Congratulations to

Milton Whaley

On being named 1989 Pharmacist of the Year by the NCPhA.

We all appreciate your dedication and many contributions to Pharmacy in North Carolina. A special thanks for all the help that you have given us over the years.

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The Mortar-and-Pestle Award is presented to L. Milton Whaley, left, by Immediate Past President Albert F. Lockamy Jr. *Photo by Qualex-Colorcraft*

Mortar and Pestle Award Recipients: *left to right, first row;* John Hood, Ralph Rogers, Jean Provo, Rheta Skolaut, Milton Whaley, Jimmy Creech, June West and Barney Paul Woodard. *Second row;* B.R. Ward, Bill Randall, Milton Skolaut, John Henley, Jack Watts and Tom Burgiss. *Photo by Qualex-Colorcraft*

Milton Whaley Honored as 1989 "Pharmacist-of-the Year"

Lloyd Milton Whaley of Durham and Wallace was honored as 1989 North Carolina "Pharmacist of-the-Year" at the Mortar and Pestle Dinner held at the Sheraton Imperial Hotel and Towers Friday, July 21, attended by over two hundred pharmacists, friends and relatives. Whaley's selection was previously announced at the Annual Convention of the North Carolina Pharmaceutical Association at Myrtle Beach in May.

Whaley was selected for this honor by the Executive Committee of the NCPhA who sponsored the evening, based on his contributions to Pharmacy, public health and his communities of Durham and Wallace over many years.

During the program following the dinner, tributes to Whaley were given by colleagues and friends from both towns who told of experiences with him that might have led to this honor.

Master of Ceremonies for the evening was NCPhA President Ralph Ashworth.The Mortar-and Pestle Award plaque was presented by Immediate Past President Al Lockamy. Program participants who spoke about Whaley were Dr. Corbett L. Quinn, a family practitioner from Magnolia, the Reverend Wallace H. Kirby of Durham,District Supervisor of the United Methodist Church and William D. Edmondson, Ph.D., also of Durham, Vice President Government Affairs and Professional Relations, Glaxo Inc. A musical treat was provided by the Triangle System Barbershop Quartet.

Career Highlights

Born in Duplin County Graduated from Beulaville High School
B.S. in Pharmacy, University of North Carolina – 1951
Licensed to practice pharmacy – 1951

Community Activities (Wallace)

Charter Member and Past President, Wallace Rotary Club
Chairman, Board of Directors, Thelma Dingus Bryant Library
Chairman, Official Board, Wallace United Methodist Church
Chairman, Finance Committee, Wallace United Methodist Church
Choir Member, Wallace United Methodist Church
Vice Chairman, Wallace-Rosehill High School Advisory Committee
Vice Chairman, Duplin County Board of Health
Director, Branch Bank and Trust Company

Community Activities (Durham)

Board of Directors, The Rotary Club of Durham
Chairman, Administrative Board, Epworth United Methodist Church
Chairman, Pastor-Parrish Committee, Epworth United Methodist Church
Building Committee, Epworth United Methodist Church
Director, Branch Bank and Trust Company, Durham

Professional Activities

President, North Carolina Pharmaceutical Association, 1975-1976
Executive Committee, North Carolina Pharmaceutical Association
A. H. Robins Bowl of Hygeia Award, 1972 (for community service)

Continued on page 10

Pharmacist-of-the Year

Professional Activities

President, North Carolina Pharmaceutical Association Endowment Fund, Inc.
Director, Pharmacy Foundation of North Carolina
Director and Executive Committee, Pharmacy Network of North Carolina, Inc.

Professional Employment

1987 to date	Retired, Individual Investor
1976 - 1987	Treasurer and Sales Manager, North Carolina Mutual Wholesale Drug Company
1953 - 1976	Pharmacist-Owner, Wallace Drug Company, Inc. Wallace, N.C. Whaley Drug Company, Inc., Jacksonville, N.C.
1951 - 1953	Pharmacist, Johnson's Drug Company, Jacksonville, N.C.

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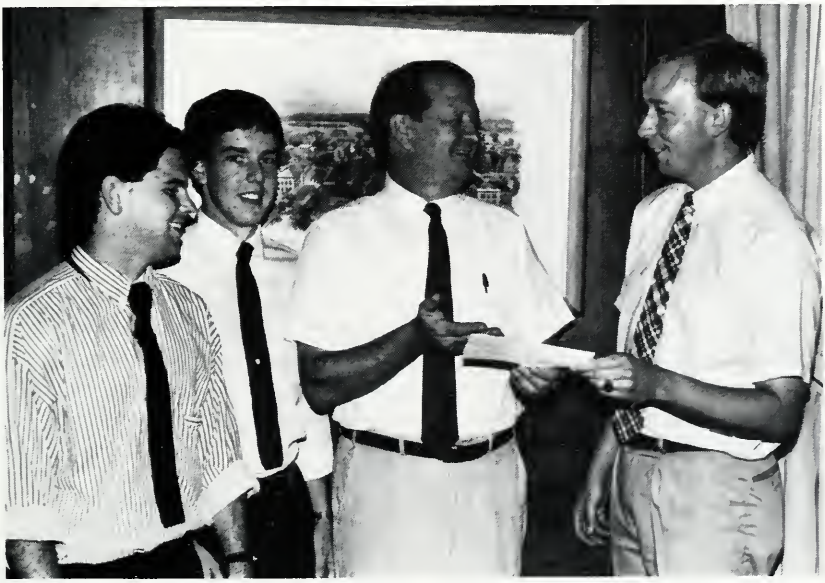
POLISHING THE OLD AND PLANNING FOR THE FUTURE

As the Beta Xi Chapter of Kappa Psi Pharmaceutical Fraternity at UNC-Chapel Hill approaches its 75th anniversary and its 20-year mark as a home owner, it is looking to the future in terms of its purpose and direction as a pharmacy organization. With a constant average of sixty to seventy members, strong leadership, and extensive involvement in the School of Pharmacy and in the community, the Fraternity has risen to a new respectability in pharmacy.

As always, Kappa Psi provides the atmosphere where pharmacy students can live and learn together, grow as leaders in the profession, develop lifelong friendships, and simply have fun. But to take things a step further, in January of this year, the chapter kicked off a new program of fund raising that will provide a resource for several programs that were designed to boost Kappa Psi's financial stability and position in the profession as well as assist members of Kappa Psi and students in the School of Pharmacy financially.

The Beta Xi Club, as the program is known, was created in January of 1989 to serve as the principal method of raising funds from alumni and other supporters of the fraternity. Under this system, contributors are recognized for their lifetime support of the fraternity and the funds that are raised go directly towards supporting the programs listed below. Supporters become members in the Beta Xi Club at different levels according to the extent of financial support. Members are recognized on a plaque that will hang in the foyer of the chapter house.

House Improvement and Solvency Fund: This program provides funds to maintain the physical integrity of the chapter house and alleviate fraternity debt. This year, the funds collected for this category were applied towards the fraternity's renovation project and also towards eliminating the remaining debt owed from bonds that were sold in 1969 in order to build the house at 208 Finley. Incidentally, the undergraduate chapter has raised over 75% of the amount needed to retire these bonds thorough fund



Establishing the Beta Xi Chapter Kappa Psi Loan Fund are Regent Alan Clark, *right* andAndrew Overman and Trent Plyler, Renovation Project Chairmen, who presented a check to NCPhA Executive Director Al Mebane, *second from right.*

continued on page 13

Hats Off To Their Hands-On Achievements.

We salute the dedication and the "can-do" spirit of these four young students, members of Upjohn's 16th Annual Internship Program, co-sponsored by the National Pharmaceutical Council and the American Pharmaceutical Association Academy of Students of Pharmacy.

For ten weeks last summer, they learned from the best possible teacher: Experience. Working side by side with top Upjohn professionals in the key areas of sales, marketing, research, and production, they experienced firsthand the ways in which theory is put into practice in the real world of the pharmaceutical industry. It wasn't easy, but what they learned from this intensive, hands-on training will serve them well wherever their careers in pharmacy take them.

The Internship Program is one example of Upjohn's continuing commitment to pharmacy. We salute these student leaders for *their* commitment to the future of their chosen profession, and wish them well in the years ahead.

Upjohn

Pictured left to right: David R. Karls, University of Wisconsin-Madison; Melissa A. Edmiston, Samford University; Carole A. Wilkins, Wayne State University; Gary C. Paul, University of Iowa

The Kappa Psi Pharmaceutical Fraternity house, 208 Finley Road

raising and alumni contributions in only 2 years. All original bond holders will be paid before the November 1989 deadline.

To supplement the amount of raised for this category, the Pharmacy Foundation of North Carolina recently loaned to Kappa Psi the remaining amount of capital required to complete the current renovation project. Renovations include ceiling and light fixture replacement, installation of central air conditioning, window and door replacement, exterior repair and painting, kitchen refurbishing, and electrical modifications in order to meet current needs. Repairs and improvements were selected by order of priority and on their potential to save money in the future. The project should be completed by mid-August of this year.

Beta Xi Scholastic Loan Program: This program was designed to support Kappa Psi Brothers in meeting school expenses by providing low interest loans with payments deferred until graduation. The administration of this program is handled by the North Carolina Pharmaceutical Association.

Kappa Psi Professional Service Award: This scholarship endowment program was created to recognize pharmacy students who demonstrate exceptional initiative through active service in health care. Each year a certificate of recognition and cash award will be presented at the Pharmacy School Awards Banquet. This program will be supported for five years from the earnings of the $10,000 bond payment made to the Pharmacy Foundation of North Carolina in order to allow the fraternity time to build its own scholarship endowment to sufficient size.

Kappa Psi Fraternity Endowment: This fund was established to ensure long-term stability through a consistent source of income to meet future financial obligations. Funds from this program will be provided to meet emergency expenses and to make future permanent improvements to the Kappa Psi House.

In its first year, Kappa Psi supporters contributed more than $4,500 for these programs. The next drive for membership in the Beta Xi Club will be made in early 1990. Please direct any comments or questions about the Beta Xi Club to:

Kappa Psi Fraternity, Beta Xi Chapter
attn. Regent
208 Finley Golf Course Road
Chapel Hill, North Carolina 27514
968-9971

ANNUAL REPORT OF THE CONTINUING EDUCATION COMMITTEE

The Continuing Education Committee of the North Carolina Pharmaceutical Association had its initial meeting for the 1988-89 year at the Institute of Pharmacy on Sunday, November 20, 1988. During that meeting, the Committee discussed the following topics.

I. A Review of Committee History

A. Accomplishments of the Continuing Education Committee were reviewed, primarily focusing on the last five (5) years of the Committee's work.

B. The purpose of the Continuing Education Committee was discussed. It was established that the committee serves the Association in the following ways:

1. Serves as an advisory body to the Continuing Pharmaceutical Education (CPE) Review Panel.
2. Identifies current topics of interest for future Continuing Education programs for the pharmacists of our state.
3. Strives to assure appropriateness of programs in terms of
   a. Quality
   b. Quantity
   c. Availability
   d. Applicability to current practice
   e. Credentials and status of CE providers
   f. Administration of CE programs
4. Conducts on-going reviews of mandatory Continuing Education requirements in North Carolina and the Nation.
5. Assists the Executive Committee of the Association in defining the relationship of NCPhA to other organizations in providing Continuing Education for pharmacists.
6. Acts as a liaison between providers and consumers of Continuing Pharmaceutical Education.

II. A Review of Annual Continuing Education Meetings Offered By NCPhA

A. It was discussed that, on an annual basis, NCPhA primarily provides three (3) Continuing Education meetings for pharmacists in our state. These three meetings are:

1. The Socio-Economic Seminar
   a. Usually held in the month of February
   b. Topics are targeted at non-clinical areas
2. The Annual NCPhA Convention
   a. Held during the spring
   b. Topics include management in clinical areas
3. The Pharmacy Practice Seminar
   a. Held during the fall, usually in the Wilmington area
   b. As a general rule, focuses its topics on current issues in community pharmacy practice.

III. Co-Sponsorship of CE Meetings

A. The NCPhA usually co-sponsors CE meetings with the UNC School of Pharmacy and possibly other professional organizations.

B. It was discussed that co-sponsorship should also be considered with other Schools of Pharmacy, as well as possibly considering other health professional schools, such as:

1. Medicine
2. Dentistry
3. Nursing

C. It was also discussed that co-sponsorship could be considered with other professional organizations in pharmacy and other allied health societies.

IV. Future Topics

A. It is recognized that being able to identify topics for Continuing Education programs in pharmacy can be somewhat problematic.

CE COMMITTEE REPORT

B. The Committee agreed that additional methods by which to identify desirable topics for future programs should exceed those being given through feedback from members of the Committee.
C. Preliminary ideas were discussed and members were asked to bring additional ideas to the spring meeting of the CE Committee before making recommendations to the Annual Convention.

V. Current Status of Mandatory Continuing Education

A. A discussion ensued regarding the current standards for mandatory Continuing Education in North Carolina based on an historical perspective of CE as a result of the latest legislation.
B. The issues including, but not limited to, the following were discussed:
1. Total number of hours currently required in North Carolina as to its appropriateness
2. The number of contact versus non-contact hours
3. Feedback from pharmacists regarding the current status in our state
C. The current requirements for mandatory Continuing Education in the Southeast and the Nation was discussed. It was agreed that a review should be conducted regarding the states that require Continuing Education at this time and the number of hours prescribed by law. Chairman Daniel Teat agreed to conduct this survey and report to the members of the Committee as to its results during the spring meeting before the Annual Convention.

VI. ACPE Provider Status

A. It was reiterated that NCPhA has customarily conducted Continuing Education programs under the auspices of joint sponsorship with an ACPE-approved CE provider.
B. Members of the Committee discussed whether or not the NCPhA should apply separately for ACPE provider status.
C. Future programs should continue to be conducted with ACPE-approved providers, rather than committing manpower and financial resources of the Association to achieving this goal on our own.

The second meeting of the CE Committee scheduled for the spring was held on Sunday, April 30, 1989 at the Institute of Pharmacy. The purpose of the second meeting was to review work which had been accomplished by the Committee during its fall meeting and to develop recommendations to be presented to the Association during its Annual Convention in North Myrtle Beach. As a result of the second meeting the following conclusions and recommendations were developed.

I. Review of Committee History and Purpose

A. It was agreed that the purpose and function of the Continuing Education Committee is appropriate at this time.
B. Recommendations:
1. The Committee's operational function should continue as outlined during the first meeting of the CE Committee.
2. No definitive changes should be implemented at this time.
3. The Committee should continue to re-evaluate its function and purpose as it relates to the North Carolina Pharmaceutical Association.

II. Survey of Annual Meetings

A. It was felt that three or four (3 or 4) annual meetings per year serves the CE needs of the Association's members.
B. The seasonal approach to meetings should be continued with one meeting each during winter and spring and either one or two (1 or 2) meetings held during the fall.
C. Recommendations:
1. The Association should consider reviewing at least one segment of Basic Therapeutics for practicing pharmacists each year.

Continued on page 17

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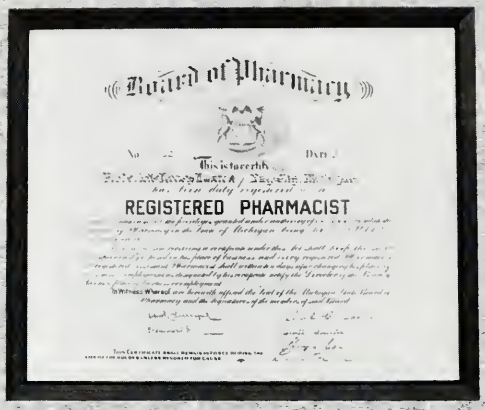

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CE COMMITTEE REPORT

2. The possibility of considering regional meetings as opposed to standardized meetings in a particular city each year should be considered.
3. A fourth CE meeting sponsored by the Association would probably be best held in the fall.
4. It was unanimous that the summer season is an inappropriate time to conduct Association-sponsored CE meetings due to vacations, etc.

III. Co-Sponsorship of CE Meetings

A. It was agreed that Continuing Education programs offered through the NCPhA should be based on ethical precepts and subject to approval by the CPE Review Panel.

B. Recommendation:

1. Continue to co-sponsor meetings with the Schools of Pharmacy.
2. Consideration may be given to co-sponsorship with other health professional organizations.
3. Consideration may also be given to co-sponsorship with other state pharmacy associations which are in close proximity to North Carolina.

IV. Future Topics

A. A discussion of using the videotape format for provision of Continuing Education programs was discussed.

B. In addition, the lack of programs dealing with professional development of the pharmacist was also reviewed.

C. Recommendations:

1. Future topics for Continuing Education programs should include, but not be limited to:
   a. Stress Management
   b. Time Management
   c. Substance Abuse
   d. Communications Skills for the Practicing Pharmacist
   e. Basic Diagnostic Procedures and Home Diagnostic Tests
   f. Clinical Review and Therapeutic Applications for Non-Prescription Drug Products
   g. Respiratory Therapy
2. An advertisement may be placed in *The Carolina Journal* of Pharmacy each January soliciting ideas from pharmacy practitioners in our state for future CE programs. The ad could provide the 800-number for the Association so that pharmacists could respond on a timely and convenient manner.
3. At least one program per year should be devoted to professional career development of practicing pharmacists.
4. More attention may be given to providing programs either in part or total through the workshop, small group discussion format.

V. Review of Mandatory Continuing Education

A. A survey was conducted by Daniel Teat, with the assistance of Mr. David Work of the North Carolina Board of Pharmacy, regarding states which currently require mandatory Continuing Education. A copy of the survey of those states may be found attached to this report in Appendix A.

B. Recommendations:

1. The number of required CE hours for practicing pharmacists in North Carolina should remain at ten (10) hours per year, at this time.
2. Additional history of dealing with mandatory Continuing Education in our state may necessitate changes in the number of required hours in the future, although it is recognized that it will be a laborious process because it necessitates legislative changes.
3. Based on a comparison of North Carolina with other states in the southeastern region of our nation, it is concluded that North Carolina is within the current realm of thought regarding mandatory Continuing Education.
4. It is also concluded that pharmacists are generally satisfied with the

Continued on page 18

current status of Continuing Education in our state as evidenced by:

a. Fewer complaints being registered with C.E. providers.
b. Increased attendance at both statewide and local CE meetings.
c. Positive comments regarding Continuing Education at this time.

VI. General Recommendations

A. Exhibitors at the Annual NCPhA Convention

1. Consider soliciting companies other than pharmaceutical manufacturers as exhibitors for the Annual Convention (e.g. Home Diagnostic Kit manufacturers, Ostomy Supply companies, etc.)
2. Companies such as these may be recruited through an approach such as: "For the first time ever, the NCPhA invites you to be an exhibitor at our Annual Convention".
3. Schedule a non-competitive time for the exhibits during the Convention.
4. Use an incentive system to have pharmacists visit the exhibits such as offering one (1) hour of Continuing Education credit or other incentives as deemed appropriate by the Association.

B. Car Pool Ideas

1. The CE Committee recommends to local associations and societies to offer car pool programs for pharmacists in a local area to attend CE meetings.
2. An approach such as this would not only improve attendance, but efficiency in conducting local association business as well.

Respectfully submitted,

Daniel W. Teat, Pharm.D.
Chairman
Continuing Education Committee

Summary

of Recommendations for the 1988-89 Continuing Education Committee of the North Carolina Pharmaceutical Association

I. Review of Committee History and Purpose

Recommendation:

1. The Committee operations function should continue as outlined during the first meeting of the CE Committee.
2. No definitive changes should be implemented at this time.
3. The Committee should continue to re-evaluate its function and purpose as it relates to the North Carolina Pharmaceutical Association.

II. Survey of Annual Meetings

Recommendations:

1. The Association should consider reviewing at least one segment of Basic Therapeutics for practicing pharmacists each year.
2. The possibility of considering regional meetings as opposed to standardized meetings in a particular city each year should be considered.
3. A fourth CE meeting sponsored by the Association would probably be best held in the fall.
4. It was unanimous that the summer season is an inappropriate time to conduct Association-sponsored CE meetings due to vacations, etc.

III. Co-sponsorship of Continuing Education Meetings

Recommendations:

1. Continue to co-sponsor meetings with the Schools of Pharmacy.
2. Consideration may be given to co-sponsorship with other health professional organizations.
3. Consideration may also be given to co-sponsorship with other state pharmacy associations which are in close proximity to North Carolina.

CE COMMITTEE REPORT

IV. Future Topics

Recommendations:

1. Future topics for Continuing Education programs should include, but not be limited to:
   a. Stress Management
   b. Time Management
   c. Substance Abuse
   d. Communications Skills for the Practicing Pharmacist
   e. Basic Diagnostic Procedures and Home Diagnostic Tests
   f. Clinical Review and Therapeutic Applications for Non-Prescription Drug Products
   g. Respiratory Therapy
2. An advertisement be placed in the Carolina Journal of Pharmacy each January soliciting ideas from pharmacy practitioners in our state for future CE programs. The ad could provide the 800-number for the Association so that pharmacists could respond in a timely and convenient manner.
3. At least one program per year should be devoted to professional career development of practicing pharmacists.
4. More attention may be given to providing programs either in part or total through the workshop, small group discussion format.

V. Review of Mandatory Continuing Education

Recommendations:

1. The number of required CE hours for practicing pharmacists in North Carolina should remain at ten (10) hours per year, at this time.
2. Additional history of dealing with mandatory Continuing Education in our state may necessitate changes in the number of required hours in the future, although it is recognized that it will be a laborious process because it necessitates legislative changes.
3. Based on a comparison of North Carolina with other states in the southeastern region of our nation, it is concluded that North Carolina is staying in the current realm of thought regarding mandatory Continuing Education.
4. It is also concluded that pharmacists are generally satisfied with the current status of Continuing Education in our state as evidenced by:
   a. Fewer complaints being registered with Continuing Education providers..
   b. Increased attendance at both state wide and local CE meetings.
   c. Positive comments regarding Continuing Education at this time.

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B. Car Pool Ideas

1. The CE Committee recommends to local associations and societies to offer car poll programs for pharmacists in a local area to attend CE meetings.
2. An approach such as this would not only improve attendance, but efficiency in conducting local association business as well.

Presented at the annual convention of the NCPhA in Myrtle Beach,SC.

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NC PHARMACIST SELECTED AS NATIONAL PRECEPTOR OF THE YEAR

Steve Wilson, Preceptor of the year

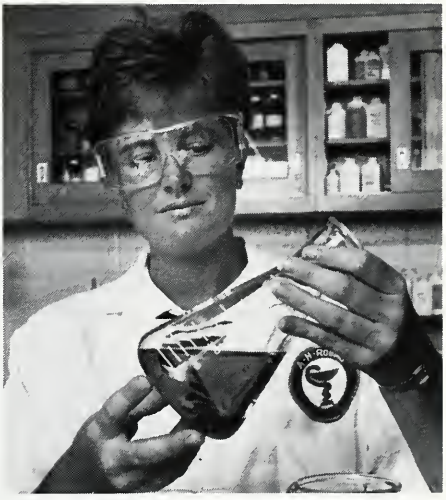
Thomas Steve Wilson, owner and pharmacist-manager of Guilford College Thrift Drugs in the Quaker Village Shopping Center in Greensboro and a preceptor for the University of North Carolina at Chapel Hill School of Pharmacy, has been named **National Preceptor of the Year** for 1989 by NARD and Syntex laboratories.

The award, which includes a $1,000 scholarship from Syntex to a college of pharmacy in Wilson's name, will be presented at the NARD annual convention in San Antonio, Texas, in November.

Earlier this year, Wilson was selected as the UNC School of Pharmacy Syntex Practitioner-Instructor of the Year for his contributions of time, talent and effort. He was recognized at the NCPhA Convention in Myrtle Beach for this state award. Steve was one of more than 400 practitioner-instructors across North Carolina who offered their time and expertise to pharmacy students this year.

Wilson is a native of Madison and is a 1969 graduate of the University of North Carolina School of Pharmacy. After graduation, he worked in the Washington DC area with Drug Fair and in Roanoke Virginia with Peoples Drug. He is now the owner of Guilford College Thrift Drugs, Battleground Avenue Thrift Drugs and Wilson Medical Sales and Rental. Steve is married to the former Charlene Searson of Saluda, South Carolina, a graduate of the University of South Carolina School of Pharmacy. They have one son, Alex, who is ten years old.

Preceptors, or practitioner-instructors, are practicing pharmacists who accept students into their worksites for four to sixteen weeks per semester to provide hands on-experience in various pharmacy settings. These volunteers provide an invaluable service to pharmacy students, who must complete 640 hours of experiential learning in practice sites before earning a degree.



Laurel Anderson, 5th year student at UNC School of Pharmacy, worked in a research lab at A.H. Robins Co. in Richmond as her internship efforts this past summer.Laurel spent 10 weeks working in research and development, quality control, production and marketing.The popular summer program, sponsored by the National Pharmaceutical Council, is in its 17th year.

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DICKINSON'S PHARMACY

by Jim Dickinson

The truth about generics. The current scandal about FDA approval of generic drugs has everybody asking: "**Are generics safe**?"

By the middle of August, this year-long federal investigation had caused thousands of anxious people to begin calling FDA in Washington, its regional offices around the country, and Capitol Hill – to say nothing of their own doctors and pharmacists.

- The issue is both complicated and not as bad as you might think.

To understand it, you need to recognize that generic drug companies have a far different "culture," or mindset, than the big innovator drug firms. Until recently generic drug operators have mainly used their own money, rather than stock-market investors' funds.

That has let them take more chances in the marketplace than the big companies are known for taking.

The other thing you need to remember is **that FDA doesn't do its own testing**. It relies on the honesty of the drug companies that submit test data to FDA reviewers for assessment.

Although the risk-taking generic drug industry has had its ups and downs before, FDA has always managed to stay on top of it. That suddenly changed around 1985, hindsight now tells us.

That's when the 1984 Waxman-Hatch Drug Price Competition and Patent Term Restoration Act finally began allowing new generic copies of big post - 1962 innovator drugs to enter the market.

It's also when a little-known FDA budget cut took place: the closure of the FDA Drug Chemistry Laboratories that used to analyze random samples of new products.

Nobody can say for sure how all this interrelates, but my feeling is that some of the risk-takers decided it was getting safer to switch ingredients, fake test results, and bribe susceptible FDA employees to expedite the review of your drug while slowing down your competitor's.

The switching of ingredients had been an occasional characteristic of generic drug companies for years, and was something the the sampling program would catch from time to time.

There weren't a lot of switches, and they never involved active ingredients – just colors, binders, fillers, and so on. But they did occasionally affect dissolution (i.e. bio-availability).

The risk-takers thought it didn't matter if, when they ran out of one excipient during a run, they just (illegally) put in another.

Whenever FDA caught up with these changes through its sampling program, the company would get a regulatory letter, and repeated offenses would result in a freeze on their new product approvals.

After the Drug Chemistry Laboratories closed and the sampling stopped, I believe the risk-takers' switching practices got more and more ambitious over time.

Now, I'm only talking about a minority of generic drug companies here. But since new companies began forming after 1984's new law came into being, it's hard to tell which firms were doing what without FDA's knowledge.

The Reagan Administration's official policy at FDA in those days was "voluntary compliance" – a naive idea that companies would do the right thing if only you were patient and gentle in educating them.

Then, sometime in 1987 or 1988, some risk-takers' switching became heavy-duty.

Vitarine employees actually tipped Dyazide into their own triamterene/hydrochlorothiazide capsules and took them to be tested for bioequivalence. Naturally, the results were perfect, and FDA gave approval for marketing.

Several other companies are alleged to have done the same thing, and counting all the excipient-switching and data falsification FDA suddenly began discovering, dozens of generics have been recalled.

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DICKINSON'S PHARMACY

(Continued from page XX)

Are generics safe? When you consider that the only documented cases of active ingredient switching are about generic Dyazide copies, and when you consider that Dyazide is probably the toughest drug in the world to copy, the the answer is probably yes. (Dyazide's bioavailability is so poor and variable that better-bioavailability Maxzide was actually developed out of unsuccessful efforts to copy the SmithKline Drug).The excipient-switching is a serious problem, and FDA is reactivating its sampling program to deal with it. But the fact remains that we have no evidence of harm from the other risks that the generic risk-takers have been taking.

Incidentally, how sure are we that no brand-name companies ever get into this kind of hanky-panky with their generic lines? I'm told their corporate bureaucracies are too thick, with too many sign-offs and checklists, to let them do what the lean-and-hungry, racy little generic guys can do.

Redundancy is something that the generic risk-takers said they couldn't afford.

This feature is presented on a grant from "Dickinson's Pharmacy – The Independent Voice," an 8-page practical monthly newsletter available from Ferdic, Inc., P.O. Box 848, Morgantown, WV 26507-0848 at an annual subscription fee of $45.

TO: MEMBERS OF THE NORTH CAROLINA PHARMACY ASSOCIATION

I would like to take this opportunity to clarify the most recent information on Mead Johnson's product "Desyrel Dividose 150 mg".

As you know, Sidmak began producing a non-dividose trazodone 150 mg tablet on June 9, 1988. Since that time, other companies have also introduced versions of this product.

Because these generic products cannot be broken into three 50 mg segments, are very difficult to break (especially for the elderly) and when broken, fail functionality tests (segment weight within +- 15% of target weight) more than 50% of the time, the FDA has amended The Orange Book to reflect the difference between Desyrel Dividose and the generics.

Mead Johnson does not dispute the bioequivalence or dissolution properties of the generic products; however, when prescribed in fractional tablets, there is a problem with functionality. Research shows that Desyrel Dividose is frequently prescribed in fractional tablets.

Here are results of one study:

Audatrex verbatim Database
(copies of actual prescriptions)

	N	%
Whole Tablet (150mg)	163	40.5
Fractional Tablet	198	46.5
As Directed Use	46	11.4
Illegible	6	1.5

In light of this information, Mead Johnson has asked me to request an opportunity to present this data before the Association asking that the "qualifier" informaton be published in your newsletter stating the Desyrel Dividose should not be substituted when prescribed in divided doses.

Thank you for your consideration.

Sincerely,

Bonnie Carollin
State Government Sales Associate
Bristol-Myers

AROUND THE STATE

This column features news briefs about persons and events related to pharmacy in North Carolina. The staff of the Journal welcomes your comments and any contributions you wish to make to this column. Photos are encouraged if possible. Send us your news!

In The News

Dr. Charles A. Sanders has been named by Glaxo to head the company following the promotion of Dr. Ernest Mario to chief executive of Glaxo's parent company, Glaxo Holdings plc in London. Dr. Sanders, formerly vice chairman of the Squibb Corp. in Princeton, NJ, will oversee Glaxo's RTP headquarters and the manufacturing plant in Zebulon. He will also be responsible for Glaxo's Latin American subsidiaries. Sanders, a cardiologist, has spent much of his career in management. Before joining Squibb in 1981, he oversaw 9,000 employees and an annual budget of $350 million as general director of Massachusetts General Hospital in Boston.

When Martin C. Goodman started preparing packages of Goodman's headache powders in his drugstore in Winston-Salem during the 1930's, he had no idea that his secret formula would become a multi-million dollar business in the 1980's. The now famous pain killer powder packages, known as "Goody's are distributed in 18 states from the manufacturing plant located in Winston-Salem.

The Proprietary Association has been renamed as the Nonprescription Drug Manufacturers Association (NDMA). The Association, first formed in 1881, represents more than 80 US manufacturers and distributors of nonprescription medications.

In the early 1900's, New Bern pharmacists, Caleb Bradham, invented Pepsi-Cola —though he proudly called it "Brad's Drink" then. In 1902, Bradham registered his trademark with the state and gave the carbonated drink its now familiar name, owing it to one of the ingredients, pepsin. The first home office of the Pepsi company still stands in New Bern.

The town of Gibson is bidding farewell to a landmark business which has operated continuously in the town for more than 100 years—The Gibson Drug Co. Longtime owners, **Keith and Evelyn Hunsucker**, are retiring after more than 20 years at the drugs store. Presently, the Hunsuckers have no immediate plans other than to sleep in when they want.

After 50 years in the retail pharmacy business, **Robert Fairley**, pharmacist-owner of Doctors Building Company in Salisbury, will retire. Fairley is a 1952 graduate of the UNC-CH School of Pharmacy. The traditions of the 35-year old pharmacy will remain, however, under the new ownership of Jerome Turchin from Mr. Carbon, WV. Welcome to North Carolina, Jerome!

Charlie Drum, owner of Drum's Pharmacy in Enfield, has purchased, 79-year old Harrison Drug Store. All of the prescription files and store stock from Harrison's will be transferred to Drum's Pharmacy.

Tim White has purchased 60-year old Hayes Barton Pharmacy in Raleigh from William "Bill" Wilson. White plans to renovate the store including the popular neighborhood fountain and grill. Wilson will continue to work at the store.

continued on Page 26

AROUND THE STATE

William R. McDonald III, mayor of Hickory since 1981, has announced that he will run for re-election next year. McDonald was owner and president of Ninth Avenue Pharmacy and Viewmont Pharmacy in Hickory.

USP has credited Vic DeLapp with reporting on a product that became the subject of a nationwide recall.DeLapp, a clinical pharmacist at Annie Penn Hospital in Reidsville, reported finding a piece of cardboard in a bottle of Nystatin Oral Suspension 100.000 U/ml. This observation led to a Class II nationwide recall of 610,285 units because the product failed to content uniformity specifications. NCPhA supports the USP Drug Product Problem Reporting Program and encourages pharmacists to report any product quality inconsistencies one may encounter.

Sunset Drug Store owner, **Alan Kennedy**, recently acquired a second store when he purchased The Drug Center in Monroe. All of the customers files and computers from the newly acquired store will be moved to Sunset Drugs.

Michael Reinhart, Iron Station, recently participated in "Old Timer's Day" in Lincolnton. Among the day's festive activities, local stores, including Lincoln Drugs where Michael is employed, featured outdoor sales booths. The event was organized by the Uptown Lincolnton Planning Committee to raise funds for beautification and improvement projects for Lincolnton's central business district.

Honors, Awards, Citations

Toni Sowell, Swansboro, has been elected Woman of the Year by the Swansboro Charter Chapter of the American Business Woman's Association (ABWA). She is eligible to compete for the 1989 Top 10 Business Women at ABWA's 1989 national convention in November. Sowell is a pharmacist at Kerr Drug in Cape Carteret.

Staff of the Journal

Kathryn Kuhn Jefferson, Manging Editor of the *Journal*, and the person most responsible for getting "caught up" with the publishing dates, is on sabbatical until January, 1990. Jefferson is serving as the second George P. Provost Editorial Intern at the Bethesda, Maryland headquarters of ASHP. She has been on staff of the NCPhA since late in May, 1988.

Weddings

Darrell Wayne Avery and Glenda Joyce Vick, both of Carrboro, were united in marriage on June 3 at Peace Free will Baptist Church. Wayne is a student at the UNC School of Pharmacy and is employed by Kerr Drug.

From the Schools

Dr. Kathy Webster, assistant professor of pharmaceutical sciences at Campbell University, has received the pharmacy school's first federal research grant. Dr. Webster received a $75,000 grant from the National Institute of Environmental Health Sciences Council.

Steve Wilson, sales representative, Glaxo, was recently presented an award from Campbell University School of Pharmacy student branch of the American Pharmaceutical Association in recognition of his service to the profession of pharmacy.

Affiliate News

The **Northwest Pharmacists' Association,** in conjunction with STEP ONE: The Center for Drug Abuse Treatment and Prevention, has been coordinating a program for older adults in local communities called, "Elder-Aid: Using Drugs Wisely". The Association first teamed up with STEP ONE in 1980. Together, they developed the program to share information with the elderly about the effects of prescription and OTC medication. Lori Setzer coordinates the

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The Carolina Journal of Pharmacy welcomes submission of articles by our members and readers. Articles relating to pharmacy or pharmacists in North Carolina, new drugs and techniques, issues in pharmacy and letters to the editor are solicited. All submissions are subject to peer and editorial review and all articles published become the property of *The Carolina Journal of Pharmacy.*

Also welcome are brief (one or two paragraph) items about NCPhA members, accomplishments, awards, births and marriages, election or appointment to service posts in city, county state or federal government. Black and white photographs should be sent when possible.

Local and regional pharmacy organizations are encouraged to send their meeting dates and places for inclusion in the **Calendar of Events**, and a paragraph or two reporting each meeting so others in the state can see what they are doing. Calendar items should be submitted at least 5 weeks prior to the month you want it to be published.

Manuscripts should be typed on standard 8 1/2 x 11 inch bond paper and double spaced. They should be free from typographical errors and editor's notes.

AROUND THE STATE, continued

scheduling of pharmacists who volunteer their time to speak at the program. Church and social groups make frequent requests for the program.

Fifty seven pharmacists attended the **Western Pharmaceutical Association** meeting on June 25 in Asheville. Merck, Sharp & Dohme sponsored a dinner and lecture on ACE inhibitors given by Edward Conradi, M.D., from USC at Charleston. Officers for the 1989-90 term are: President, Mike Overman; President-elect, Toni Sisk; Secretary, Francina Rogers; Treasurer, Tom Allison; and Board Members, Dale Massey, Ruth Higgins and Jan McCallum.

CONFIRM THAT DEA NUMBER

There is a formula for detecting a prescriber's falsified DEA number. Add the first, third and fifth digits; add the second, fourth and sixth digits and multiply that sum by two. Add the two resulting numbers and the last digit of this sum will be the same as the last digit of the DEA number.

Example
Take the DEA number
1234563

1 + 3 + 5 =		9
2 + 4 + 6 =	12	
12 x 2 =		24
Total	=	33

The last digit of the total (33) is "3" which corresponds to the last digit in the DEA number 1234563

Brenda Lyles cares for children. As a mother, a health care professional, and a concerned citizen.

After tending to her three children, Brenda turns to the health care needs of her community. As an Eckerd Pharmacist, she provides medication to children afflicted with illness. After work, she leads the people of Lexington, South Carolina in fund-raising efforts to support Camp Kemo, a special summer program designed for children with cancer.

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HOSPITAL PHARMACIST POSITIONS

STAFF PHARMACIST: Beaufort County Hospital located in Washington, NC. A 151 bed community hospital. Full unit dose, computerized IV ad mixtures and chemotherapy. Contact D.D. Winstead at (919) 975-4293.

HOSPITAL PHARMACIST WANTED: Pardee Memorial Hospital, a 270 bed hospital, including 40 bed skilled nursing. Located 25 miles south of Asheville. Seeking one pharmacist. Call (704) 693-6522 or send resume to Ken Wallace, Pardee Memorial Hospital, 715 Fleming St., Hendersonville, NC 28739.

PHARMACIST OPPORTUNITY: Gaston Memorial Hospital is currently seeking applicants for a pharmacist position in our 479 bed acute care facility. The pharmacist department offers 24 hour service and features a computerized unit dose system, IV admixtures and clinical services. Gaston Memorial is located in Gastonia, just 15 miles west of Charlotte, North Carolina's major metropolitan area. The position requires a highly motivated person with a strong base of dispensing, monitoring, and communication skills, therapeutics knowledge and a caring attitude. Along with a competitive salary, plus dental coverage, TDA, tuition reimbursement and credit union. The comprehensive salary/benefit plan includes relocation expenses plus an additional employment bonus of $1,000. Gaston Memorial Hospital offers today's professional progressive, stimulating environment which encourages learning and provides an opportunity for professional growth. Pharmacists interested in this position should submit a resume or contact Personnel Services, Gaston Memorial Hospital, P. O. Box 1747, Gastonia, NC 28053-1747, (704) 866-2141.

COMPUTER COORDINATOR: Presbyterian Hospital in Charlotte is currently seeking applicants for a computer coordinator/pharmacist position. Responsibilities include daily management, refinement and development, auditing and monitoring, and training for all computer systems within the Pharmacy. The position requires a highly motivated, experienced hospital pharmacist with extensive experience utilizing in-patient pharmacy systems and PC applications (including spreadsheet, database, and word processing). Interested candidates should send resume to: Personnel Department, Presbyterian Hospital, P.O. Box 33549, Charlotte NC 28233

STAFF PHARMACIST wanted at Hugh Chatham Memorial Hospital and Hursing Center. Competitive salary and benefits. Contact Jeff Seaford, Parkwood Dr., Elkin, NC 28621 or (919) 835-3722.

COMMUNITY PHARMACIST POSITIONS

PHARMACIST WANTED: Pharmacist interested in managing independent store 30 miles north of Charlotte. Closed nights, weekends and holidays. Excellent salary, good benefits and possibility of ownership. Reply to Box TBX, c/o NCPhA, P.O. Box 151, Chapel Hill, NC 27514.

PHARMACISTS WANTED: Due to rapid growth Kerr Drug Stores now have positions available for pharmacists in Raleigh, Fayetteville, Charlotte, Pinehurst and Greensboro. Kerr Drug offers opportunity for growth into store management. Excellent benefits. Send resume to Jimmy Jackson, P.O. Box 61000, Raleigh, NC 27661, or call (919) 872-5710.

PHARMACIST OPPORTUNITIES: Excellent environment in which to demonstrate professional skills. Positions available for the very best in many locations in the Carolinas. Excellent compensation and benefit programs including generous bonus and profit sharing. Join the leader in the Carolinas. Call Gary Judd at Eckerd Drugs, (704) 371-8242 to explore mutual interests.

PHARMACISTS: REPUTATION...IT OFTEN DEPENDS ON THE COMPANY YOU KEEP!! Join the leader in the retail drug industry since 1905. As a staff or management pharmacist, you will receive a comprehensive compensation and benefit package including incentive program. Convenient locations available in the Mid Atlantic area. Practice in a professional atmosphere with a corner drug store image. CALL PEOPLES DRUG STORES, Andrea Moskin, R..Ph. at (800) 336-4990, X6810 or (703) 750-6810.

PHARMACIST WANTED: We are seeking an ambitious and professional career-minded individual for a pharmacist manager position in Southeastern NC near the coast. Computerized Rx records, excellent salary, paid vacation, hospitalization and life insurance. Professional pharmacy located in the middle of a medical complex. Investment opportunity available. Contact William D. Smith, P.O. Box 1782, Morehead City, NC 28557.

REVCO, an industry leader in the operations of community drug stores, is actively seeking full-time, professional pharmacists who are interested in a prosperous association with a growth-oriented company. We have openings in Denver (on Lake Norman), Gastonia, Winston Salem, Walnut Cove, and Albemarle. We offer a complete benefit package including medical, dental, life, and disability insurance, tax shelter profit-sharing, savings program, Rx bonus, and continuing education. If you are looking for an association with a dynamic and expanding drug store chain, call Recie Bomar at 1-800-444-4223. EOE.

PHARMACISTS NEEDED: For Rite-Aid stores in Sparta, Mount Airy, and Asheville area. For more information contact Jan Musten at (919) 789-4003.

PHARMACY MANAGER: No nights or Sundays. Burlington area. Professional atmosphere. For more information call (919) 933-9732.

RELIEF PHARMACIST POSITIONS

RELIEF PHARMACIST AVAILABLE: Central & Eastern North Carolina. Hospital or retail. Contact Pharmacy Relief, P.O. Box 2064, Chapel Hill, NC 27515 or call (919) 481-1272 evenings. Leave message.

RELIEF PHARMACIST AVAILABLE: For weekend work in Central and Eastern North Carolina. Leave message (919) 485-4815.

RELIEF PHARMACIST AVAILABLE: Live in Chapel Hill will travel to any part of state. 19 years experience in retail. Please leave message. (919) 942-3879.

PHARMACISTS NEEDED: Full-time or relief work in western NC. Contact Sunwood Medical Professional Services. (704) 872-9499.

RELIEF PHARMACIST AVAILABLE: Live in Durham. Prefer Triangle Area. Retail and Hospital experience. Please leave message. (919) 544-5599.

RELIEF PHARMACIST available within a 3 hour drive of Raleigh. Call (919) 552-2838.

RELIEF PHARMACIST AVAILABLE: For work in Charlotte and Central North Carolina areas. Call (704) 542-3341.

FIXTURES FOR SALE

ANTIQUE STORE FIXTURES FOR SALE: Includes display cases, soda fountain, wall fixtures. Contact Charles Chapman at (704) 933-7775.

FIXTURES FOR SALE: Used drug store fixtures for sale. Call Dale Knight at (919) 494-2287.

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FOR SALE : "Hallmark" card department sign, metal construction, approximately nine feet long, brown painted finish, originally cost $1,200.00, will now sell to best offer. Call Sam at (919) 269-7036.

PHARMACIES FOR SALE

PHARMACY FOR SALE: Pharmacy for sale in Piedmont. Gross sales over $300,000 a year. Contact Box TVD, c/o NCPhA, P.O. Box 151, Chapel Hill, NC 27514.

PHARMACY FOR SALE: Located in Wilmington, NC. Gross sales $375,000. Extremely profitable. Reasonably priced. Contact Bullock & Whaley, P.O. Box 3764, Wilmington, NC 28406 or call (919) 395-5898.

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MISCELLANEOUS

PHARMACIST AVAILABLE: Professional Services/Consultation - Temporary and/or Continual. Contact: L. W. Matthews at (919) 967-0333 or 929-1783, 1608 Smith Level Road, Chapel Hill, NC 27514.

PHARMACIST OPPORTUNITY: Do you want to stand still as a chain pharmacist. Do you yearn to own your own drug store? Here is an opportunity for you! Coastal NC location. professional practice environment, nursing home provider, computerized pharmacies, option for part ownership. Call Don Heaton at (919) 453-8500 for an appointment to look.

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FOR SALE: PC/1 pharmacy software package originally purchased at $9,500.00 will sell for $2,500.00 due to independent pharmacy gone out of business, also NCR cash register $200.00. (919) 488-8964 (days) / (919) 483-9991 (nights).

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VISITING RESEARCH INSTRUCTOR: The ideal candidate should have a pharmacy degree and possess strong clinical skills. Experience in drug regimen review and medication administration survey will be helpful Didactic skills and teaching experience in one-to-one situations and the delivery of technical assistance will be a plus. This exciting position will allow the candidate to interact with others in a research program examining drug prescribing, administration and drug regimen review in long term care, and devolop strong skills and experience in the management, operations and logistics of research in pharmaceutical services in long term care. A half time position is available on the visiting research instructor level. North Carolina travel is required. Inquiries and applications for this fixed term appointment should be directed to: Abraham G. Hartzema, Ph.D. M.S.P.H., Associate Professor, Division of Pharmacy Administration, CB# 7360, Beard Hall, Chapel Hill NC 27599-7360.

Notice:

Because of the increased cost of publishing *The Carolina Journal of Pharmacy*, it is necessary to enhance the revenue from the Classified Ads. **Effective January 1990 issue,** the rate will be 25¢ a word for members with a minimum of $5.00 per insertion. For non-members, the rate is 50¢ a word with a minimum of $10.00 an insertion.

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NOVEMBER 1989 VOLUME 69 NUMBER 11

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Because stores would need extra merchandise, trucks rolled again on Saturday, stocked with supplies we knew would be in demand, such as distilled water. On Monday, September 25th, a special truck was sent to Greensboro and Burlington to secure more batteries and distilled water. This truck's return was delayed until 10:00 pm, and only through extra efforts of the night crew were we able to deliver these products the very next day.

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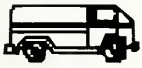
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THE CAROLINA
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Pharmacy Calendar

1989

December 3-7	ASHP Midyear Clinical Meeting, Atlanta
December 3	NCPhA Executive Committee, Chapel Hill

1990

January 22-23	NC Board of Pharmacy Examinations
February 1-2	NCSHP Winter Meeting, High Point
February 6	UNC School of Pharmacy Career Day
February 9-11	NC Leadership Forum, Mid Pines
March 10-14	APhA Annual Convention, Washington
March 18-24	National Poison Prevention Week
March 22	24rd Annual SocioEconomic Seminar, High Point
April 7	Parents Day, Campbell University
May 7	Campbell School of Pharmacy Graduation
May 7-8	NARD Legislative Conference
May 13	UNC School of Pharmacy Graduation
May 23-26	NCPhA Annual Convention, Durham
June 3-7	ASHP Annual Meeting, Boston
June 25-26	NC Board of Pharmacy Examinations
September 6-9	First Seminar on "Issues in Pharmacy Today", Asheville
September 16	Pharmacy Practice Seminar, Wilmington
September 24-25	NC Board of Pharmacy Examinations
November 21-25	NARD Annual Convention, Nashville
December 2-6	ASHP Midyear Clinical Meeting, Las Vegas

Other Dates of Interest

ASHP

1991	Annual Meeting-San Diego	June 2-6
1991	MidYear Clinical Meeting-New Orleans	December 8-12
1992	Annual Meeting-Washington, DC	May 31-June 4
1992	MidYear Clinical Meeting-Orlando	December 6-10

NARD

1991	Annual Meeting-Baltimore	October 27-31
1992	Annual Meeting-Seattle	October 25-29
1993	Annual Meeting-Indianapolis	October 24-28
1994	Annual Meeting-Boston	October 16-20
1995	Annual Meeting-Las Vegas	October 8-13

APhA

1991	Annual Meeting-New Orleans	March 9-13
1992	Annual Meeting-San Diego	March 14-18
1993	Annual Meeting-Houson Area	

CAMPBELL UNIVERSITY SCHOOL OF PHARMACY FALL CONVOCATION, SEPTEMBER 7, 1989

Johnny Kerr, President of Kerr Drug Stores

President Wiggins, Dean Maddox, distinguished guests on the podium, future pharmacists and — not at all least — parents of the future pharmacists here today:

I wish to express, first of all, my gratitude at being asked to address the School of Pharmacy Convocation for the year 1989.

I didn't hesitate to accept because previously I have visited your school and have had the pleasure of meeting a lot of people here at the school. I found it particularly refreshing to hear administrators talk without apologies about the need for teaching values.

My message today is for you students out there, and it relates directly to many of the values Campbell University celebrates — the values of hard work and learning, the values of making choices and accepting responsibilities to build a better community for ourselves and our children.

What I want to talk to you about today can be summed up in one word — CHOICE. In particular, I want to talk about choice as a cornerstone of the basic tenets of our political system, the political system that will govern and affect your rights as a pharmacists. This cornerstone is made up of the freedom of choice, the courage to choose, and accepting the responsibility of the consequences. The idea I want to offer for your consideration today is that every problem we face as individuals and as a society boils down to a matter of making the effort to make choices or to avoid making choices. Usually the failure to resolve a problem results from refusing to make choices.

Now I could come here and tell you plenty about the particular problems that health care and pharmacy are facing. But — as I said — all the problems facing the health-care industry boil down to the choices you are now making and the choices you will make in the future.

I an sure that by now you've at least given some thought to the possibility of socialized medicine in this country. I believe that we will definitely experience some version of socialized medicine because the choices are being made that will lead to it.

Whether you are just beginning your studies or nearing their completion, I want to encourage all of you to think about the future — not just about your own futures — but about the futures of the small towns to which many of you plan to return, about the future of this state and about the future of our nation. You, as individuals, will be making the decisions and living the lives that will determine the vitality of our nation. You — especially as students of pharmacy — need to understand how important the choices you make will be determining the future of pharmacy.

Because making choices is of such supreme importance, I'd like to illustrate what I mean by telling you the stories of two men — two very different men who grew up under different conditions and who faced different challenges.

One man was born in Austria in 1927; the other was born in Mooresville, in southwestern North Carolina, in 1923. One was a Jew;

Continued on page 6

FALL CONVOCATION

the other was a Methodist. As a young boy and man, oneof them lived through a modern nightmare of persecution and imprisonment; the other "came up" in the South during the depression of the 1930's, the son of a red-clay farmer who also kept a small store to bring in what was then called "cash money."

Both of these men started their lives with very little, although one was born in this country and the other came here seeking refuge from religious and ethnic persecution. But, you may know the old saying, "If can't have what you choose, you choose what you have." Both of these men chose what they had. Even though they grew up under very different circumstances, each man was infused with self reliance and the courage to make choices.

In these two stories, I hope you will also see that anything might be possible for you, no matter where you come from or where you go. Whether you end up in New York City, Elizabeth City, or Mexico City — your choices, your way of life and your values will guide the life of this country.

John G. Stoessinger was born in Austria in 1927. Recently, I heard him speak about his life and about the world economic situation at the convention of the National Association of Chain Drug Stores. His story is one of horrible brutality, lucky coincidence and courageous persistence.

Stoessinger was six years old when Hitler and the Nazi party came to power in neighboring Germany. In 1938, as the Nazis were consolidating their so-called "annexation" of Austria, Stoessinger fled to Prague in Czechoslovakia with his Grandfather, a printer. Stoessinger was separated from his parents, Oscar and Irene Stoessinger, during this period and never saw them again. For the next seven years, Stoessinger would live the life of a refugee.

In March of 1939, six months before Hitler's invasion of Poland, Germany was in complete control of Czechoslovakia. Although the coming terror and brutality of Hitler's Reich is obvious to us now, in 1938 and 1939 most of the people in the world, including most Americans, had no idea of what Hitler was planning, In essence, the world had decided to make no choices about the meaning of Hitler's evident plan for aggressive expansion. As Stoessinger said of this experience, "We thought, like a lot of Jews, that Hitler would be satisfied; that's why six million of us were killed."

Stoessinger's mother, his father and his grandfather were three among the six million killed. Stoessinger himself was able to escape from Czechoslovakia and travel through Russia — a dangerous business for an Austrian Jew — to Vladivostok in Siberia. By the time the Japanese attacked Pearl Harbor, Stoessinger had somehow followed the trail of many other Jewish refugees to Japanese-occupied Shanghai, where 20,000 Jews would live out the war in captivity.

As part of their occupational possessions, the Japanese had captured a British public school, complete with the headmaster staff. the school was allowed to continue with its schedule, and Stoessinger — enrolled, receiving under these extraordinary circumstances one of the best college preparatory educations available in the world.

After the Japanese surrender, Stoessinger was transported to Japan as an international refugee. There he struck up a friendship with a group of GI's who were impressed with the young man's intelligence. His GI friends thought so much of Stoessinger, in fact, that they raised enough money to send him to Grinnell College in Grinnell, Iowa — a college about the size of Campbell.

As Stoessinger told his story, it was at Grinnell that he discovered the double-edged meaning of freedom in the United States.

It was the first day of classes and students were filing into the classroom. As Stoessinger — still frail from his years of captivity — was studiously taking down the professor's first remarks, a corn-fed football player breezed into the room, saying "howdy prof," and — in a leisurely way — made himself comfortable in a couple of chairs in the back of the room.

This wasn't the way students behaved toward teachers in Austria or in Shanghai. The freedom to challenge authority was not something he or any other refugee could easily understand. Where Stoessinger had come from — and he had been to a lot of places — the authorities or military did not tolerate disrespect or dissent. He had seen people killed for making casual remarks like the one he had just heard.

It was in this classroom that John Stoessinger came to the sudden crucial realization that — for the firs time in his life — he was free. I think what he was experiencing was a society that was — for the first time in his life — saying to him, "It's up to you now, John. You choose which path you'll take." The football player may have chosen to goof off and may have experienced the consequences, or he may have chosen to succeed in school. Either way, it was up to him.

Stoessinger had come to see that, in America, each person chooses his or her own way in life, but in choosing, accepts the responsibilities of freedom and the risk of individual failure. It is possible that Stoessinger's football player "wised up" during his college years; it is possible that it took him longer. If and when that person did learn the need to act responsibly, American society was ready for him.

Stoessinger saw that individual freedom also made America a place of second chances. many of us here today have failed or have decided to take a second chance. Some of you students already have degrees in other disciplines, but you decided to take a second chance with pharmacy. All of us here today have experienced failure and disappointment in one way or another during our lives, but all of us are able to take that second or third or fourth chance. We can do this in America.

Stoessinger — who had known the world as a place where most of his people had no chance at all — would not need a second opportunity to prove himself in the United States. After graduating with honors in Political Science form Grinnell, he was awarded a graduate fellowship at Harvard, where one of his classmates was Henry Kissinger.

After earning his Ph.D. in Political Science, Stoessinger devoted many years to teaching and writing. He taught at MIT, at the Colorado School of Mines and — for most of his life — at Hunter College in New York City. He has published ten books on foreign relations, some now in 7th and 8th editions. His book "The Might of Nations" is standard reading for any political science student.

As Stoessinger told this story to the audience of drug store executives — a story of the brutality of Hitler, Stalin and the Japanese military — he argued that American businesses, and specifically the American pharmaceutical and medical industries should "be alive and receptive" to the idea of doing business in the Soviet Union.

Whether Stoessinger is right or wrong about the opportunities for American business in Russia, it is remarkable to me that a man with his experience of persecution and terror would be encouraging business people to give the USSR a second chance. Most people in his position would not believe that change is possible in the USSR; that the government in that country is beginning to understand that individual rights and freedoms are necessary to the success of a modern society.

A clue to Stoessinger's remarkable — and very American belief that anything is possible, even in the USSR, is found in the preface to one of his books, "Nations in Darkness." In that preface, Stoessinger refers to his early life and makes the following statement:

"There are two fundamental ways in which a man can deal with tragic experience: he can get stuck in the past and do battle with its ghosts, or he can come to terms with it and try to fashion it into strength."

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CAMPBELL FALL CONVOCATION

Stoessinger's remark can be used to describe an element that has always been present in the American experience. Most Americans are from the stock of refugees who came to this land to escape persecution or injustice. They were escaping places where they had no right to choose a way of life or a religion. They saw that America would allow them to make their own choices and to live by them. This national experience is still with us. We believe that anyone can transform tragedy into strength, and we believe that the freedom of choice and the rights of the individual are what make this transformation possible.

The second of the two stories I want to tell you today is the story of my own father, Banks D. Kerr. He was born in Mooresville, North Carolina, in 1922, the fourth of five children born to my grandparents, Price and Ethel Kerr. Price Kerr was, as I said earlier, a farmer and small businessman, scratching out a living for his family and setting ambitious goals for all of his children.

Raising five children during the 1920's and then especially during the depression couldn't have been an easy life. Just to refresh your memory, allow me to list a few examples of how devastating the Great Depression was:

1. Between 1929 and 1932, general business activity in the United States was cut in half — from a Gross National Product of $104 billion to a GNP of $58 billion.
2. During the same period, national income fell from $81 billion to $41 billion dollars.
3. At its peak in 1933, national unemployment was estimated at 25% of the work force — and I think we need to remember that women were not usually counted as a part of the work force at that time.

This was the reality. In the South — which was already far behind the North in economic development — the standard of living decreased more than these nation-wide statistics indicate. Can you imagine how your life would change if our present economy were cut to half its size?

But my grandfather — like so many fathers and mothers at that time — believed that the future would be better for his children. He believed that education was important — that it was the key to succeeding in the future — and he believed in a family working together.

He concentrated his and the family's efforts on seeing that all the children would graduate from a college or university. Grandfather "invested" — as he called it — $300 to enroll his oldest child, Lois, in Saint Andrews College. While she was in school and after she graduated, my aunt Lois was expected to help pay for the next child to go to college. The next helped the next and, in turn, they all helped each other. Like Kerr Drugs today — and like the businesses many of you will be returning to — it was a family effort.

Despite the economic obstacles of the depression, all but one of my grandfather and grandmother's children graduated from college. The sisters, Lois, Violet and Helen graduated from St. Andrews College with teaching degrees, and they all became teachers. Aunt Lois taught high school for about 30 years in Union County. Aunt Violet taught third grade for about 25 years, and aunt Helen also taught for a few years before "retiring" to raise a family of her own — if that can be called retirement.

To me and my family, my aunts' stories are as important as the story of Banks Kerr — because hundreds and hundreds of people today were taught to read and write and to think by them.

My father and his younger brother, Johnny — who is my namesake — attended UNC. Johnny studied business and my father, who had worked in a country drug store while in high school, entered the School of Pharmacy in Chapel Hill. During his first year, my father was paying his own way, taking odd jobs at 25 cents an hour and getting what help the family could offer. His high school grades were not high enough to earn him a first-year scholarship, but, during his

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CAMPBELL FALL CONVOCATION

freshman year, he earned the grades necessary to win a scholarship for the rest of his time at UNC.

That was in the early 40's. The United States was at war. Two weeks before his graduation my father's bother, Johnny, went into the Army Air Corps. He became a B-25 pilot and was shot down near Tunisia during the Allied invasion of Italy.

After my uncle Johnny was killed, Banks Kerr felt that it was his duty alone to fulfill his father's dreams for both boys. He stayed on to graduate at age 20 from UNC'S School of Pharmacy. By that time, he ranked first in the pharmacy class of 1943.

After graduating, my father moved to Norfolk, Virginia. There he met my mother, Dorothy Renfrom Kerr, and — while he was still under the legal age to run a pharmacy — he managed a small drug store owned by a Norfolk doctor. In early 1945, he enlisted in the Army Medical Corps and was sent to the Pacific and eventually ended up in Osaka, working as a pharmacist at one of the US Army's medical centers. True to form, he was also running a photo developing operation of his own, sending home the money he made.

As I think you can see, Banks Kerr was interested from the beginning in combining pharmacy and business — no matter where he was or what else was happening. He showed the persistence and enterprise that is needed to create a successful business. What he didn't have was the capital to start one.

Following my father's service in the Army, my parents moved to Greensboro. For about four years, Banks Kerr managed a Ligget drug store there, but he was always looking for a way to start up his own store.

In 1950, that opportunity came — not in Greensboro but in Raleigh — where a man by the name of Willie York was building the first major shopping center between Washington and Atlanta. My father saw Cameron Village as the ideal place to begin and test what was then a new retail concept: the self-service drug store.

He sold the house, the car and scraped together an initial investment of $12,000. He and my mother risked everything. She worked right along-side my father in the first years, and she was also raising my sisters and me.

Cameron Village was a success and — with long hours and hard work — so was the first Kerr Drug Store. My father had made a difficult decision — to relocate and start a business. Because of this decision, he changed his life and his family's lives. In 1958, my father opened a second Kerr Drug store in Goldsboro. By 1962 there were six Kerr Drug stores serving the cities of Raleigh, Durham and Goldsboro.

In 1980, we opened our 30th store, and we will end this year with 94 Kerr Drug stores in operation.

Both John Stoessinger, the World War II refugee, and Banks Kerr, the son of a red-clay farmer, demonstrated what can be done in this country. They demonstrated that it is possible for a single person to succeed through making active choices about the future. Both men were rewarded by choosing to achieve what may have seemed impossible, and both men were willing to take the risks and the responsibilities for their choices.

All of us here today can look forward to a future of making choices and accepting responsibilities. History, and the two stories I've told today, show us that we should not avoid choices and that we should not and cannot avoid taking responsibility for our choices.

The question is, how do we prepare for the future? What choices to we make? And — specifically — how do we prepare for the future of pharmacy in a very uncertain and troubling time for our industry and for the medical industry as a whole.

Just about everybody in this country is disturbed by the rising costs of medical treatment. In a recent nation-wide survey, people indicated that their number-one fear

was the prospect of not being able to pay for proper medical care throughout their lives. To me, this survey shows that America's confidence in its medical system is eroding.

Unfortunately, this erosion of confidence is advancing. The federal government — in allowing entitlement programs like medicare to grow far beyond their original designs and purposes — has helped to create an environment in which the demand for medical services has increased. And — because of the realities of supply and demand — medical costs and private insurance premiums are rising at a rate well above inflation.

In fact, demand and costs are rising at such a rapid rate that both the government and many private insurers are now unwilling or unable to pay for the services they have promised. Without regard to rising costs, the government and private insurers are setting the price they will pay for certain services and pharmaceuticals. As a result, many institutions, doctors and medical suppliers are refusing to supply goods and services at at loss.

And, most important to all of us, sick people are many times caught in the middle — unable to pay insurance premiums, or unable to meet large co-payments, or unable to qualify for treatment under the rules of government programs.

In many people's eyes, the inevitable next step is socialized medicine — a national health program run by the federal government. As you work toward your degree in pharmacy, this issue will affect your plans and your careers. If you and I choose to avoid the problem, the inevitable will happen. The United States will come under some form of socialized medicine within your lifetimes.

If you and I avoid the hard choices, one of the great challenges and rewards of pharmacy — especially for the pharmacist/business-person — will disappear. There is still old-fashioned retail incentive in pharmacy, the kind of incentive that rewards you and your customers. This incentive is a result of our freedom to choose between opening a business or working for a business.

Right now we are able to choose between and accept the different responsibilities of the business person or the employee. Are we going to choose to maintain this right of choice?

In the near future, it will be our choice as individual pharmacists either to go along with the idea that socialized medicine is inevitable — that it is the only solution our health-care problems — or to discover a better alternative, one that will uphold the values of individual freedom, self-reliance and freedom of choice.

It will be your responsibility, as well as mine, to discover this alternative to the mediocrity of centralized medicine. It will be our responsibility to uphold the freedom of choice that is at the heart of our system of democracy and also at the heart of the greatest health-care system in the history of the world. With all of our problems, our country remains as the model for free societies.

Right now, we are seeing this idea of freedom spreading throughout the world — in Hungary, in Poland and, we hope, in the Soviet Union. Tragically, freedom does not come cheaply or easily. We have witnessed this truth in the recent massacres in China. Many of the people killed, tortured and imprisoned are students — students who are literally risking their lives to enjoy the freedom of choice that you now enjoy.

My question to you is this: Are we — through avoiding our responsibilities and the tough choices — going to allow our freedoms to slip away? I hope not. I hope that we — like the murdered Chinese students — are courageous enough to fight for our freedom of choice, one of the most important tenents of our democratic system. If we decide to fight for our freedom of choice, there will be responsibilities that we chose freely. And, most important, if we continue to fight for freedom of choice in the United States, we will succeed in passing on to our children — and perhaps even to the world — what our parents and their parents before them gave to us: the right to choose and to accept responsibility for our choices.

SOUTHEASTERN STATES MEDICAID DATA

(August 15, 1989)

	Fee	*Cost*	*Total Claims*	*Expenditure*	*Average Rx*	*Formulary*
AL	3.75	WAC = 9.2%	3,710,767	44,701,304	12.05	YES
FL	4.23	WAC = 7%	9,000,000	162,000,000	17.99	NO
GA	4.42	AWP - 10%	7,519,592	111,007,153	16.59	YES
KY	3.25	AWP-5%	8,000,000	47,114,186	11.20	YES
LA	4.00	AWP-10.5%	6,109,545	86,566,602	14.16	NO
MD	3.70	AWP Mod.	3,250,190	45,329,906	16.13	NO
MS	3.75	Blend of AWP/ AAC & MACs	3,490,000	43,913,962	15.18	YES
NC	4.24	AWP	5,000,000	85,000,000	17.00	NO
SC	4.05	AWP-9.5%	1,989,276	32,385,000	16.28	NO
TN	3.91	AWP-8%	7,228,635	106,576,686	14.74	YES
VA	3.40	AWP	4,737,106	71,095,784	15.01	NO

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CONTRAINDICATIONS

DITROPAN® (oxybutynin chloride) is contraindicated in patients with increased intraocular pressure (ie, glaucoma) associated with angle closure, since anticholinergic drugs may aggravate this condition.

It is also contraindicated in partial or complete obstruction of the gastrointestinal tract, paralytic ileus, intestinal atony of the elderly or debilitated patient, megacolon, toxic megacolon complicating ulcerative colitis, severe colitis, and myasthenia gravis. It is contraindicated in patients with obstructive uropathy and in patients with unstable cardiovascular status in acute hemorrhage.

DITROPAN is contraindicated in patients who have demonstrated hypersensitivity to the product.

WARNINGS

DITROPAN® (oxybutynin chloride), when administered in the presence of high environmental temperature, can cause heat prostration (fever and heat stroke due to decreased sweating).

Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with DITROPAN would be inappropriate and possibly harmful.

DITROPAN may produce drowsiness or blurred vision. The patient should be cautioned regarding activities requiring mental alertness such as operating a motor vehicle or other machinery or performing hazardous work while taking this drug.

Alcohol or other sedative drugs may enhance the drowsiness caused by DITROPAN.

PRECAUTIONS

DITROPAN® (oxybutynin chloride) should be used with caution in the elderly and in all patients with autonomic neuropathy, hepatic or renal disease. DITROPAN may aggravate the symptoms of hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, hiatal hernia, tachycardia, hypertension, and prostatic hypertrophy. Administration of DITROPAN® (oxybutynin chloride) to patients with ulcerative colitis may suppress intestinal motility to the point of producing a paralytic ileus and precipitate or aggravate toxic megacolon, a serious complication of the disease.

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PREGNANCY. Category B. Reproduction studies in the hamster, rabbit, rat, and mouse have shown no definite evidence of impaired fertility or harm to the animal fetus. The safety of DITROPAN administered to women who are or who may become pregnant has not been established. Therefore, DITROPAN should not be given to pregnant women unless, in the judgment of the physician, the probable clinical benefits outweigh the possible hazards.

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ADVERSE REACTIONS

Following administration of DITROPAN® (oxybutynin chloride), the symptoms that can be associated with the use of other anticholinergic drugs may occur:

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Dermatologic:	Decreased sweating, rash.
Gastrointestinal/ Genitourinary:	Constipation, decreased gastrointestinal motility, dry mouth, nausea, urinary hesitance and retention.
Nervous System:	Asthenia, dizziness, drowsiness, hallucinations, insomnia, restlessness.
Ophthalmic:	Amblyopia, cycloplegia, decreased lacrimation, mydriasis.
Other:	Impotence, suppression of lactation.

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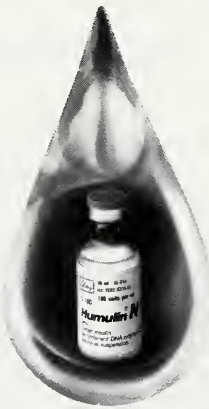

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I certify the statements made by me above are correct and complete.

Alfred H. Mebane III,
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CORRESPONDENCE COURSE: THE NEW DRUGS OF 1988-89

by Thomas A. Gossel, R.Ph., Ph.D.
Professor of Pharmacology and Toxicology
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Goals

The goals of this lesson are to identity and discuss new drugs approved by FDA and/or marketed during 1988 and 1989.

Objectives

At the conclusion of this lesson, the participant should be able to:

1. exhibit knowledge of the drugs discussed by pharmacologic and therapeutic classification;

2. choose the indications, mechanism of action, benefits and limitations of the drugs discussed;

3. identify adverse effects and drug interactions associated with the drugs; and

4. demonstrate an ability to counsel patients on these new drugs.

Twenty new chemical entities were approved as drugs by FDA during 1988 (Table 1). Of these, 13 were sanctioned in the last two weeks of the year. The 20 new chemical entities compare favorably with previous year: 21 in 1987, 20 in 1986, 30 in 1985, and 22 in 1984.

The FDA new drug classification system depicted in Table 1 indicates the categorization of a new drug for the particular indication (s) that the manufacturer requested when it filed its New Drug Application (NDA) for that drug. Following marketing, as additional uses may be approved, the designation will change.

For example, misoprostol was granted "1A" status for the indication listed in Table 1. If the drug is approved for treatment of peptic ulcer disease, it will then be designated as a "4", appropriate to the indication as listed at the bottom of Table 1.

The following discussion will review the new drugs of 1989-89 by pharmacologic classification.

Cardiovascular

CARTEOLOL (Cartrol)

Carteolol is a long-acting, nonselective beta-adrenergic blocker with intrinsic sympathomimetic activity (ISA). Because of the latter property, it does not depress the resting heart rate as much as other beta blockers devoid of ISA. Compared to other commercially available beta-adrenergic block-

The New Drugs of 1988-89

Table 1

Name	Sponsor	Classification	Indications/Use
Astemizole (Hismanal)	Janssen	1C	Non-sedating H1-antagonist
Butyl methoxy-dibenzoylmethane and Padimate-O (Photoplex)	Herbert	1C	OTC full-spectrum sunscreen
Carteolol (Cartrol)	Abbott	1C	Antihypertensive
Cefotiam (Ceradon)	Takeda	1C	Antibiotic
Diclofenac (Voltaren)	Ciba-Geigy	1C	NSAID for arthritis
Exametazime (Ceretec)	Amersham	1B	Imaging agent
Ethanolamine (Ethamolin)	Glaxo	1B	Prevention of rebleeding of esophageal varices
Flutamide* (Eulexin)	Schering	1B	Antiandrogen for treating prostatic carcinoma
Gadopentetate dimeglumine (Magnevist)	Berlex	1B	Imaging Agent
Ifosfamide (Ifex)	Bristol	1A	Third-line chemotherapy of germ cell testicular cancer
Iovesol (Opriray)	Mallinckrodt	1C	Imaging Agent
Mesna (Mesnex)	Asta	1B	Prevention of ifosfamide-induced hemorrhagic cystitis
Misoprostol (Cytotec)	Searle	1A	Precention of NSAID-induced gastric ulcers
Naftifine (Naftin)	Herbert	1C	Antifungal

Nicardipine (Cardene)	Syntex	1C	Antihypertensive and antianginal
Nimodipine (Nimotop)	Miles	1A	Subarachnoid hemorrhage
Nizatidine (Axid)	Lilly	1C	H2 – antagonist
Octreotide (Sandostatin)	Sandoz	1A	Symptomatic treatment of carcinoid tumors and VIPomas
Oxiconazole (Oxistat)	Glaxo	1C	Antifungal
Pergolide (Permax)	Lilly	1B	Adjunct to levodopa/ carbidopa in the treatment of Parkinsonism
Tiopronin (Thiola)	Mission Pharmacal	1B	Kidney stone formation

* Approved 1989.
FDA new drug classification system 1 = new chemical entity, 2 = new salt, 3 = new combination, 4 = new dosage form, 5 = generic drug, 6 = new indication; A = significant therapeutic gain, B = moderate therapeutic gain, C = little or no therapeutic gain.

CARTEOLOL, contd.

ers, it is closest to pindolol (Visken) in pharmacologic action.

Carteolol is scheduled to be available in three strengths: 2.5 mg, 5 mg, and 10 mg tablets, and will be taken once a day for treatment of hypertension. Doses above 10 mg per day are unlikely to produce additional benefits in therapy. Since the market for beta blockers is competitive, its manufacturer is contemplating whether it will release the drug.

Adverse effects from cateolol are similar to other beta-adrenergic blockers. These include aggravation of congestive heart failure, headache, dizziness and drowsiness, hypotension, insomnia and/or anxiety. Nausea, vomiting, and abdominal pain are also reported. Carteolol appears to penetrate the blood brain barrier poorly. Consequently, it may cause fewer adverse effects on the central nervous system than some of the others drugs in its class.

NICARDIPINE (Cardene)

A calcium channel blocker chemically related to nifedipine, nicardipine is indicated for treatment of angina pectoris and hypertension. The drug was developed in Japan and is reported to be the largest selling calcium channel blocker there.

As with other calcium channel blockers, nicardipine inhibits influx of calcium ions into smooth muscle. This relaxes vascular smooth muscle and lowers blood pressure. Its action in treating angina is related to its ability to relax coronary vascular smooth

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NEW DRUGS OF 1988-1989

NICARDIPINE , contd.

muscle at serum levels that cause little or no negative inotropic effects. Nicardipine has only minimal effects on sinoatrial and atrioventricular nodal function. It therefore has little cardiac depressant activity and does not have anti-arrhythmic action. It has also been used for Raynaud's disease and congestive heart failure.

Nicardipine can cause wide swings in blood pressure between peak and trough levels. Physicians are therefore advised to monitor pressure responses at peak (1 to 2 hours) following initiation of therapy, and trough (i.e. at equilibrium, approximately 8 hours) to assess patient response to therapy.

Side effects are characteristic for the calcium channel blocker group. These include actions associated with vasodilation (headache, flushing, and edema), cardiac palpitations, hypotension, depression, dyspnea, and anxiety.

NIMODIPINE (Nimotop)

Another calcium channel blocker, nimodipine reduces the incidence of neurological deficit following spasm of the cerebral arteries that often accompanies subarachnoid hemorrhage. The outcome of preventing cerebral artery spasm is improvement of cerebral blood flow. Nimodipine differs from other calcium channel blockers in that it readily crosses the blood-brain barrier, and is relatively selective for cerebral arteries.

The drug is available in 30 mg soft gelatin capsules. At a dose of 2 capsules every 4 hours for 21 days, therapy should begin 4 days after the subarachnoid hemorrhage occurs. Patients are at greatest risk for cerebral artery spasm beginning about day 4, through the next 21 days.

The market potential for this product for its current indication is limited. There are reportedly 25,000 patients per year with diagnosed subarachnoid hemorrhage, with about 15,000 survivors available for treatment.

Potential indications include occlusive stroke, dementia, and age-associated memory deficit. Nimodipine is in Phase III clinical trial for treatment of Alzheimer's disease. It has also demonstrated some effectiveness in preventing migraine.

ETHANOLAMINE OLEATE (Ethamolin)

This sclerosing agent is indicated for prevention of rebleeding of esophageal varices. It is not indicated for treatment of esophageal varices that have not bled. Unfortunately, it does not benefit portal hypertension, the primary cause of esophageal varices.

Antineoplastics and Associated Drugs

FLUTAMIDE (Eulexin)

The first orally effective androgen antagonist, flutamide is indicated for use in conjunction with LH-RH agonists such as leuprolide (Lupron) for treatment of metastatic prostate carcinoma. Both drugs must be stated together to achieve maximal results.

In one clinical trial of over 600 persons, patients given both leuprolide and flutamide survived 7 months longer, on average, than other patients receiving leuprolide alone. Seven months may not sound like much time, but to the patient, it can be a lifetime.

Leuprolide must be administered parenterally; flutamide is taken orally.

Approximately 12 percent of patients experience diarrhea. Other adverse effects include those expected from chemical castration: hot flashes, decreased libido, impotence, and gynecomastia (enlarged, painful breasts in males). Unlike castration which is irreversible, the result of treatment with these drugs is reversible should the patient go into remission. Approximately 12 percent of patients experience diarrhea.

NEW DRUGS OF 1988-1989

IFOSOMIDE (Ifex)

Ifosfamide is an alkylating agent with chemical structure and pharmacologic action similar to cyclophosphamide. It has demonstrated significant activity alone and in combination with other antineoplastic agents to treat a variety of cancers. If was approved for combination therapy, along with mesna, for refractive germ cell testicular cancer.

Ifosfamide is converted to an active metabolite, ifosfamide mustard. Another metabolite, acreolein is devoid of anti-tumor activity but is extremely irritating to the renal tissues. Acreolein is the suspected cause of hematuria, urinary frequency, and dysuria that are common with both ifosfamide and cyclophosphamide. Cyclophosphamide is also partly converted to acreolein.

MESNA (Mesnex)

Mesnex was approved for concomitant use with ifosfamide to protect against renal tissue toxicity associated with alkylating agent. It does not possess significant pharmacologic activity on other systems. The drug is, however, available in other countries as a mucolytic agent.

It is proposed that Mesnex acts by inactivating acrelein, a metabolite of ifosfamide and cyclophosphamide, thereby preventing renal tissue toxicity. The cytostatic activity of other active metabolites of ifosfamide and cyclophosphamide is not affected.

The most significant adverse effects include dose-related nausea, vomiting and diarrhea. A false-positive ketone urea test with Multistix has been reported. Tf has therefore been suggested that this action be used as a check to ensure that patients are actually taking mesna.

TABLE 2

Pharmacologic Effects of Octreotide

Site or Function	Effect
Blood flow to gut	Decreases
Gut hormone	Inhibits gastric acid, gastric inhibitory peptide, gastrin, secretin, vasoactive secreting peptide
Gut absorption	Decreases carbohydrate absorption, increases water absorption and electrolyte absorption
Intestinal	Decreases motility
Pancreas	Inhibits insulin, glucagon, pancreatic bicarbonate, pancreatic polypeptide
Pituitary	Inhibits growth hormone and thyrotropin secretion

Adapted from Rosenberg JM: *Drug Intell Clin Pharm* 22:748, 1988

NEW DRUGS OF 1988-1989

OCTREOTIDE (SANDOSTATIN)

Octreotide is a long-acting (t1/2 = 1.5 hours), synthetic analog of naturally-produced somatostatin (t1/2 = 1 to 2 minutes). Somatostatin helps regulate water and electrolyte balance in the intestine. If also slows GI transit time, and suppresses secretion of a number of biologically active substance into the intestine. These include gastrin, pancreatic polypeptide, insulin, glucagon, secretin, motilin, and vasoactive intestinal peptide (VIP). Octreotide exerts similar activity.

It is the latter substance, VIP, that appears to be most closely linked to octreotide's action. In excess, VIP stimulates increased secretion of water into the intestine. Since water comprises the greatest bulk of feces, the result is severe diarrhea. VIP is also a potent vasodilator.

Octreotide is, therefore, indicated for treatment of chronic and severe diarrhea and flushing that are associated with carcinoid tumors and vasoactive intestinal peptide-secreting tumors (VIPomas). The official uses for the drug are directed at a limited patient population, estimated to be 2,500 or less. It is available in prefilled syringes for self-injection.

The action of Octreotide is broad and its indications may someday be extended. Table 2 summarizes the end result of octreotide activity on a variety of tissues.

The most frequent side effect is nausea. Pain at the site of injection, loose stools (surprising, since this is the condition being treated), abdominal pain/discomfort, and vomiting are adverse effects reported above the 3 percent level.

Anti-Infectives

NAFTIFINE (NAFTIN)

Naftifine belongs to the broad-spectrum antifungal group called allylamines. The cream product is indicated for treatment of tinea cruris (Jock itch), tinea corporis (ringworm of the body), and tinea pedis (athlete's foot). One advantage is that it has a quicker onset of action than other topical antifungal products currently available.

OXICONOZOLE (OXISTAT)

A member of the imidazole group of antifungals which has activity against both tinea and candida, Oxiconazole is similar to other antifungals already available. The drug is reportedly under study for incorporation into a vaginal sponge product intended for treating yeast infections.

Prostaglandins and Prostaglandin Inhibitors

MISOPROSTOL (CYTOTEC)

Misoprostol is indicated for prevention of NSAID-induced gastric ulcer in persons at high risk of complications from gastric ulceration. These include geriatric patients, smokers, and others with a past history of ulcers or GI bleeding.

A synthetic analog of naturally produced prostaglandins, misoprostol exerts similar action, but has a longer biological half-life. One of the many roles of prostaglandins is to protect the gastric mucosa from erosion by acid and pepsin. By inhibiting prostaglandins, NSAIDs can cause GI bleeding, even ulceration. Misoprostol restores protection by maintaining the production of mucus and bicarbonate ions by gastric epithelial cells. This prevents NSAID-induced destruction of these cells and ulceration. It is estimated that approximately 200,000 cases of NSAID-related GI bleeding, with 10,000 to 20,000 deaths from complications, occur each year in the U.S.

NEW DRUGS OF 1988-1989

A strong marketing point for misoprostol is that approximately 60 percent or more of NSAID-induces ulcers are asymptomatic. This is especially true for geriatric patients. The problem is understandable because NSAIDs are analgesic and can mask early warning sign of ulceration.

Misoprostol enters the market place in competition with other agents used extensively for treatment and prevention of gastric ulcers, the H_2 antagonists and sucralfate. While they have proven effectiveness against peptic ulcer disease, they are not officially indicated for NSAID-induces GI hemorrhage.

Misoprostol is the firs prostaglandin analog approved for use on the GI tract. It has been marketed elsewhere since 1985, and is currently approved in more than 40 countries, mostly for use in treatment of peptic ulcer disease. Seven other countries currently permit marketing for coadministration with NSAIDs.

Primary adverse effects include diarrhea and abdominal pain (4 to 13 percent). The most prominent adverse effect is increased uterine contractibility with abortion (11 percent) when the drug is taken in the first trimester of pregnancy. This is of importance to physicians and pharmacists since misoprostol lists one of the most extensive contraindications and warnings relative to use in pregnancy. The manufacturer strongly recommends that Cytotec only be dispensed in its original, unit-of-use packaging that contains appropriate patient advice.

DICLOFENAC (Voltaren) and FLURBIPROFIN (Ansaid)

Diclofenac was marketed in late 1988, along with flurbiprofen (Ansaid). While these NSAIDS are new to the U.S., both have been available elsewhere for over a decade (diclofenac since 1974). Diclofenac is reportedly the largest selling NSAID worldwide with nearly 12 percent of market share.

The pharmacologic action attributed to diclofenac, classified chemically as a phenylacetic acid derivative, is basically the same as for other NSAIDS, i.e., inhibition of prostaglandin synthesis. The prostaglandins they inhibit are mediators of inflammation. By reducing synthesis, NSAIDs curtail inflammation and further damage to to the diseased joint.

A claim for diclofenac is that it causes less GI bleeding/ulceration than aspirin. Ibuprofen is the other NSAID which is permitted by FDA to make the same claim. Undoubtedly this is a major reason for its widespread use outside the U.S., and the impact it has made in this country since release. It is associated with elevations in liver-function tests in about 15 percent of patients.

Flubiprogen, the other NSAID released in 1988, had already been available as the sodium salt in another dosage form, an ophthalmic solution (Ocufen). Its pharmacologic action is similar to other NSAIDs, but it is unique in that its labeling does not recommend periodic liver function tests be performed. Although the drug was developed by Boots, Upjohn has cross-licensing rights as with Boots for exclusive rights to market flurbiprofen. In return, Upjohn granted Boots marketing rights for its enteric coated erythromycin product, E-Mycin.

This continuing education for Pharmacy article is provided through a grant from

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Other New Drugs

ASTEMIZOLE (Hismanal)

Astemizole is the second nonsedating H1-anatagonist to be approved for marketing in the U.S. it has a long half-life, allowing for once-daily dosing. Its "1C" rating compares it favorably, but without significant therapeutic gain, to terfenadine (Seldane).

BUTYLMETHOXYDIBENZOYLMETHANE + PADIMATE O (Photoplex)

This combination of 3 percent butyl methoxydibenzoylmethane and 7 percent padimate O provides sunscreen protection against both UVB and UVA radiation. The product, Photoplex, is therefore described as a "full spectrum" sunscreen. Unlike previous sunscreens, it extends protection to photosensitivepatients against the longer wavelengths of ultraviolet radiation (UVA). UVA radiation is currently thought to be more potentially damaging than UVB, because of its greater availability.

NIZATIDINE (Axid)

The fourth H2-antagonist to be marketed in the U.S., nizatidine joins the group with similar therapeutic activity. it has not yet demonstrated the drug interactions associated with cimetidine, and to lesser extent, ranitidine. Its availability in a patient "convenience pack" may offer an advantage in improvement of patient compliance. Unlike other H2-antagonists, nizatidine is available only as an oral dosage form.

PERGOLIDE (Permax)

A long-acting dopamine agonist similar to bromocriptine, pergolide was approved for concurrent use with carbidopa/levodopa (Sinemet) for treatment of Parkinson's disease. Pergolide may be useful in individuals who have experienced a decrease in responsiveness to levodopa. The drug may also be effective when used alone.

TIOPRONIN (Thiola)

Tiopronin is indicated for treatment of severe homozygous cystinuria, an autosomal recessive disorder in which excessive amounts of the amino acid are excreted. Because of its low solubility in urine, cystine stone formation may occur. The drug complexes with cystine to solubilize it. Clinical trials to date summarize tiopronin to be as effective as penicillamine in decreasing cystine excretion.

Tiopronin may cause adverse effects similar to penicillamine. These include GI responses, blood dyscrasias, myasthenia gravis, nephrotic syndrome, and a lupus-like reaction.

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Births

Stuart A. (Al) and Susan Hamm announce the birth of their second daughter, Caroline Walker, born August 24, 1989. Caroline weighed 7 pounds 71/2 ounces. Al is a 1985 graduate of the UNC School of Pharmacy and is part owner of Snow Hill and Parkwood Pharmacies. Their first daughter, Anna, is 18 months.

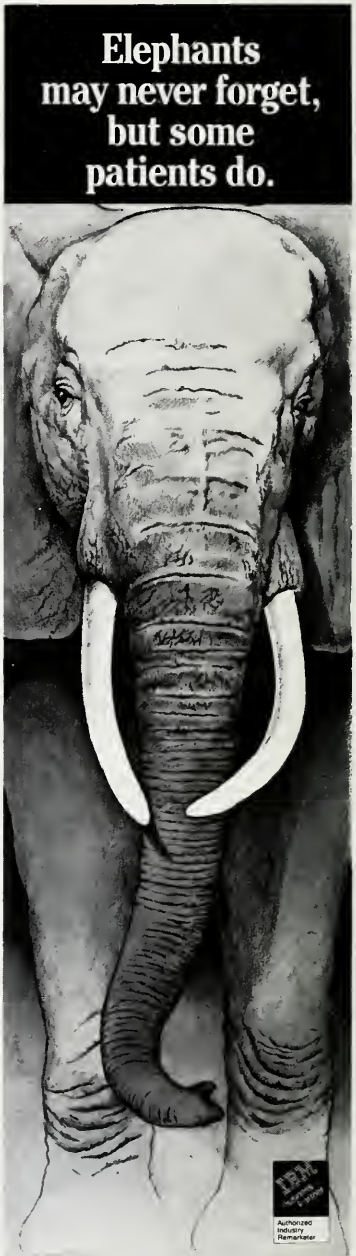
Loni T. and Mike Garcia of Graham are the proud parents of Rebecca Michelle born at NC Memorial Hospital in Chapel Hill Tuesday, October 3rd. Rebecca weighed 9 pounds 1/2 ounce at birth. Loni and Mike are moving to Greenville, SC late in November for a job upgrade for Mike.

Michael and *Elizabeth Downing*, White Lake, announce the birth of Zachary Alexander, born September 28.He weighed 9 pounds 3.5 ounces. Both Michael (1982) and Elizabeth (1979) are graduates of the UNC School of Pharmacy and are employed by Wal Mart.

Weddings

Suzanne Marie Marsh of Cary and Brian David Ward of Wake Forest were married May 21 at North Raleigh United Methodist Church. The bride is a graduate of the School of Pharmacy, University of North Carolina at Chapel Hill and is a pharmacist at Kerr Drugs. The bridegroom is a senior process engineer at AVX Corp. and is a graduate of NC State University. The couple will live in Wake Forest.

The wedding of Karen Gail Stephenson and *Stanley Oakley Watts* was at 3 p.m., May 15 in Fuquay-Varina United Methodist Church. The couple are graduates of the University of North Carolina at Chapel Hill School of Pharmacy. The bride is a pharmacist for K-Mart and the bridegroom is a pharmacist for Super-X. The couple will live in Kernersville.



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WOMAN'S AUXILIARY, NCPHA ESTABLISHES CAMPBELL UNIVERSITY PHARMACY SCHOOL STUDENT SCHOLARSHIP FUND

Betsy Mebane, Woman's Auxiliary President, announced the Auxiliary Executive Board, at its July meeting, voted to give $3000 to establish a Scholarship Fund for Campbell University pharmacy school students. They hope to match this amount in January. A committee has been formed to raise money for this scholarship fund with Mrs. Keith Fearing and Mrs. William Randall, Co-Chairman. Others are Mrs. Ronald Maddox, Mrs. Larry Good, Ms. Sarah Ann Sasser, Mrs. Henry Smith and Mrs. Jack Watts. If you wish to contribute to this fund please send your contribution to the Woman's Auxiliary, Campbell University Scholarship Fund, P.O. Box 151, Chapel Hill NC 27514.

The Woman's Auxiliary also provides the following awards to the UNC School of Pharmacy:

The Vivian Spradlin Smith Scholarship	$600.00 annually
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Correspondence Course Quiz

New Drugs 1988-1989

1. The drug that causes wide swings in blood pressure between peak and trough levels is:
   a. ethanolamine.
   b. carteolol.
   c. nimodipine.
   d. nicardipine.

2. Which of the following is the most appropriate advice to convey to a patient receiving a prescription for Cytotec?
   a. Do not take this drug if you are pregnant.
   b. Do not take this drug if you are over 65 years of age.
   c. Avoid prolonged exposure to sunlight.
   d. Avoid taking Cytotec concurrently with NSAIDs.

3. The new drug that was approved for concurrent administration with leuprolide:
   a. reduces renal damage caused by leuprolide.
   b. enhances the therapeutic response of leuprolide.
   c. protects against leuprolide-induced GI erosions.
   d. reduces skin damage by leuprolide plus UV light.

4. Octreotide is a long-acting analog of which of the following substances?
   a. Gastrin
   b. Prostaglandins
   c. Somatostatin
   d. Serotonin

5. Which of the following drugs is classed as a dopamine agonist?
   a. Permax
   b. Cardene
   c. Eulexin
   d. Ifex

6. Patients on diclofenac should be tested periodically for:
   a. peptic ulcer disease.
   b. open-angle glaucoma.
   c. liver function.
   d. cataract formation.

7. A person who excretes abnormally high amounts of cystine would be treated most appropriately with:
   a. Permax.
   b. Sandostatin.
   c. Ethamolin.
   d. Thiola.

8. Which of the following drugs is in Phase III clinical trial for treatment of Alzheimer's disease?
   a. Pergolide
   b. Nimodipine
   c. Flutamide
   d. Carteolol

9. Toxicity to acreolin is best reduced by which of the following drugs?
   a. Diclofenac
   b. Misoprostol
   c. Mesnex
   d. Nizatidine

10. A resident who asks for information on new drugs that treat symptoms of VIPomas should be told about:
   a. exametazine.
   b. tiopronin.
   c. ifosphamide.

Answer sheet is on Page 40

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		10. a b c d

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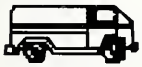
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Members of the Endowment Fund, left to right: John Zatti (Glaxo, Inc.) Robert B. Hall, Howard Q. Ferguson, M. Keith Fearing Jr., John Bowdish (Burroughs Wellcome Co.), Marshall Sasser, Milton Whaley and Ralph Ashworth. *Photo by Qualex-Colorcraft*

Suzan Maddox, Fred Eckel, Bill Edmondson and Dean Ron Maddox socializing during the Endowment Fund Dinner reception *Photo by Qualex-Colorcraft*

ENDOWMENT FUND DINNER FEATURES IRV RUBIN

The 1989 Endowment Fund Dinner was held Saturday night, October 21st at the Kenan Center on the campus of the University of North Carolina at Chapel Hill. The dinner, a fund-raiser for the Endowment Fund of the North Carolina Pharmaceutical Association, Inc., featured Irv Rubin, Editor-at-Large, Pharmacy Times, as the program speaker. The topic of Rubin's talk was "Is There a Great Wall Between Chinese and American Pharmacy.

The dinner and program were preceded by a reception at the Center. Music was provided by Musica, a string ensemble from the Chapel Hill-Carrboro area. Milton Whaley, Chairman of the Endowment Fund Board of Directors, served as Master of Ceremonies for the evening. Recognized as 1989 Endowment Fund *Members,* contributors of $1,000 or more, were Burroughs Wellcome Co., Frances Lena Rader, Robert B. Hall,E.A. Brecht, Glaxo,Inc. and G.Thomas Cornwell.

John Bowdish, left, receives the Endowment Fund Plaque for Burroughs Wellcome, Inc. from Fund Chairman Milton Whaley.

Photo by Qualex-Colorcraft

Rubin, 1986 recipient of the APhA Remington Medal, longtime editor of Pharmacy Times, and the person most credited with the development of the 8¢ US Pharmacy Stamp, told of his October 1988 trip to the People's Republic of China as part of the Citizen Ambassador Program of People to People International. He led a group of pharmacists who discussed topics of mutual interest such as medical care and pharmaceutical care with Chinese colleagues. The use of a brief video tape made by one of the pharmacists provided some of the additional highlights of Rubin's talk, including hearing Irv sing "Getting to Know You" in Chinese.

China has over one billion persons, a fifth of the world's population, stated Rubin. He quoted the Ripley's Believe It or Not column which said "If all the Chinese lined up and walked passed a given point four abreast, they would never stop passing because of the birth rate and resulting offspring would be greater than the number passing the point." There were twenty eight people in the delegation, twenty were pharmacists, including one from Charlotte who gave a talk on drug information, one of eleven talks given by members of the delegation. On the sixteen day trip, the group went to Beijing, Hong Kong and Shanghai.The Chinese drug products are largely botanicals, according to Rubin. Lectures about Chinese drugs reminded him of his classes in pharmacognosy, back in the late thirties.

All drug distribution is owned and controlled by the government. Private enterprise was making itself known in the pharmacies as was evident in the attitudes of the staff in private and government shops. There are three kinds of pharmacists in China: those with five years of college, those with three years of college and those with ten years of practical experience in pharmacy, but no formal educational training. The

Continued on page 7

IT PAYS TO STUDY YOUR OPTIONS

Graduate Studies Scholarship Program

Career opportunities in the pharmaceutical industry encompass a broad range of disciplines. To encourage pharmacy students to pursue graduate level studies in areas which may lead to pharmaceutical careers, Glaxo has joined with the American Association of Colleges of Pharmacy and the American Foundation for Pharmaceutical Education to establish the Glaxo Graduate Studies Scholarship Program.

The program will award **$5,000** scholarships to **eight** graduating pharmacy students who plan to continue their studies i graduate school. Eligible graduate programs may include such divers areas as management, engineering, pharmaceutical science: marketing and law.

Scholarship applications may be obtained by writing to: Glax Graduate Studies Scholarship Program, AACP, 1426 Prince Stree Alexandria, Virginia 22314.

Entries must be received by May 1 of each year.

Glaxo

ENDOWMENT FUND DINNER

latter pharmacists are often found in management. Hand counting and the abacus are common methods of calculations.

Rubin also dwelt on the need to "speak to the leader" when working with the Chinese. The right answer can only be obtained if the right person is asked. Bargaining is a way of life in the markets...to pay the asked-for price is the sign of an uninformed person.

This next May, Rubin will lead a similar delegation to Moscow, Leningrad and Odessa in the Soviet Union and to Stockholm, Sweden The estimated cost is $4200 and the trip will qualify for tax-exempt status for federal tax returns. For more information, contact Al Mebane at NCPhA in Chapel Hill.

NORTHEASTERN CAROLINA PHARMACEUTICAL SOCIETY

1990 officers for the NE Carolina Pharmaceutical Society installed at the Annual Banquet in Williamston are:

President—William Manning Jr., Columbia

Vice President—Monte Thompson, Ahoskie

Sec.-Treas.—Wendy Harrell, Macclesfield

Officers were installed by NCPhA Executive Director Al Mebane on Wednesday, December 6. President Dana Outen presented a check for $250.00 to Betsy Mebane, President of the Woman's Auxiliary for the Campbell University Pharmacy Scholarship Fund.

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PRESIDENT'S MESSAGE

Ralph H. Ashworth, NCPhA President

North Carolina had a large delegation of pharmacists at the November NARD convention held in beautiful San Antonio, Texas. Registration set a record with over 5,000 attending. Exhibitors provided the largest Trade Exposition ever held at an NARD convention. In addition, there were stimulating workshops and outstanding entertainment during the four day program. Highlighting the speakers were former governor of Wisconsin, Lee Dreyfus and columnist George Will.

One of the actions taken by the delegation was to go on record in favor of mandatory counseling of patients with new prescriptions. The California State Board of Pharmacy has already passed a regulation to that effect which will begin July 1, 1990. There are now thirteen states which require patient counseling. Often we see trends from California spread across the country. In many of our pharmacy settings, consultation takes place now, but in many busy pharmacies it does not. Are we ready to begin talking about this issue? How are pharmacists to be reimbursed for this service? Will we have to train technicians to fill prescriptions while we are consulting? There are many questions to be answered about a mandatory counseling service. We must be alert, keep ourselves informed and work with our NCPhA on this issue as it evolves in North Carolina.

The Catastrophic Health Care Plan, passed by Congress last year, was recently repealed. This shows how a tremendous amount of pressure from a few constituents gets results with Congress. This issue is not dead, and it's predicted that something similar will probably resurface with the next Congress. As new laws are drafted, we must keep our state and national representatives aware of the value of our professional services and demand that we are fairly compensated. We know that change is in the wind! With health care costs rising yearly, and at a much higher rate than inflation, there are increasing pressures to change our health care systems.

According to USA Today, 37 million citizens are denied access to the world's best health care system because they don't have medical insurance, are unemployed, or are not eligible for Medicaid. Robert Mercer, retiring chairman of Goodyear Tire & Rubber Co. said recently, "I never thought I would be in favor of a government health policy, but there are things we must do." Senator Edward Kennedy said, "It's time to make basic health care a basic right for all—not just an expensive privilege for the few."

With a mood spreading like this across our country, we will be having changes in our system. Let us all work together to provide our citizens with good health care and to preserve pharmacy's role.

At this holiday season, let us count our blessing of associates, friends and families. Let us also be thankful for the staff of our Association. Al, Betsy, Terri, Kathryn and Erie are dedicated, conscientious and constantly performing tasks that enable our organization to run smoothly.

Please accept my wish for each of you to have a joyous holiday season and a prosperous new year!

TMA FOUNDATION CONTRIBUTES $2,500 TO NCPHA LOAN FUND

The Traveling Members Auxiliary of the North Carolina Pharmaceutical Association recently contributed an additional $1,500.00 to the TMA Foundation Student Loan Fund for UNC—Chapel Hill students and $1,000.00 to the TMA Loan Fund for students at Campbell University School of Pharmacy. The funds are part of the Consolidated Student Loan Fund, managed by the NCPhA.

In 1969 members of the TMA voted to establish a TMA Foundation that would eventually contribute to a loan fund for needy/deserving pharmacy students. A TMA Foundation Board was elected to administer the fund. A savings account was established and contributions were accepted for a number of years until the fund was large enough for the interest to make yearly payments to a student loan fund. In 1978, the TMA Fund was established at the Institute of Pharmacy in Chapel Hill with a contribution of $500.00 to the Consolidated Student Loan Fund in memory of J. Floyd Goodrich. With additional contributions since that time, the TMA Fund balance is now almost $16,000.00

The TMA student loan fund is a part of the Consolidated Pharmacy Student Loan Fund established almost 30 years ago to make available, on relatively short notice, small loans of up to $300 a semester. According to Al Mebane, executive director of NCPhA, the TMA Fund is one of the largest individual loan funds. Al says, "No other state pharmacy association has such a program, at least in the volume we have, and pharmacists and friends of pharmacy in North Carolina should hold their heads high because of this program."

Approximately 100 UNC-CH and Campbell University students have received TMA loans as of September 20, 1989. Mebane says, "As you can see, money in these loan funds does not sit idle, but is used over and over, benefitting many students."

In 1987,the TMA contributed $520 to establish a Memorial Fund for Sara Elizabeth Clampett, infant granddaughter of Mr. and Mrs. A.H. Mebane III, who died in September of 1986.

Composed of representatives from the North Carolina drug wholesalers and from manufacturers representatives detailing the state, the Traveling Members Auxiliary has made donations to other designated parts of the UNC Consolidated Student Loan Fund such as one in memory of W.P. Brewer, a past president of the TMA.

With the opening of Campbell University School of Pharmacy with 53 students in the first class, in 1986 the North Carolina Pharmaceutical Association voted to take $5,000.00 from their Undesignated Loan Fund and establish a loan fund for Campbell University students. During that year the TMA Foundation made its first contribution of $500.00 to the Campbell University fund. Additional grants have been made annually since then.

Current officers of the TMA Foundation are Tom Sanders, chairman; C. Rush Hamrick Jr., secretary-treasurer and L.M. McCombs, assistant secretary-treasurer. Other TMA members on the board are Horace Lewis, Doug Sanders, Bill Andrews, Frank Fife, Len Phillipps, Ralph Rogers Jr., Zack Lyon, Tom Terry III, Bobby McDaniels and Roy Moss.

Tax deductible contributions to the TMA Foundation may be sent to C. Rush Hamrick Jr., Box 1806, Shelby, N.C. 28150, or to L.M. McCombs, Box 7, Creedmoor, N.C. 27522.

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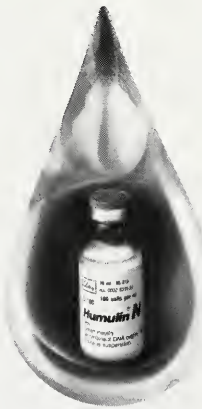

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MINUTES OF THE COMMITTEE ON PHARMACY IN THE N.C. MUSEUM OF HISTORY

The Committee on Pharmacy Exhibit at the N.C. Museum of History met on Wednesday, October 11, 1989, at the N.C. Museum of History in Raleigh. Present were 20 members of the committee and 13 guests.

After the luncheon with much fellowshipping, W.J. Smith, Chairman, welcomed everyone and thanked them for the distance traveled to attend the meeting. He introduced special guests: John Ellington, Administrator of the Museum; Eve Williamson, Executive Director of the Museum of History Associates; and Wesley Creel, Assistant Administrator of the Museum.

Mr. Smith introduced Ralph Ashworth of Cary, President of the North Carolina Pharmaceutical Association for announcements. Ralph thanked W.J. and Vivian and the committee for the work accomplished on our exciting project. He announced that Milton Whaley had consented to serve with W.J. as co-chairman of this important committee. He also announced that Milton Skolaut will be serving as Chairman of Committee on Corporate Solicitations, a very special assignment to contact corporate friends of pharmacy regarding funds to assist with our project. To date, we have $3,000 in donations, being held by the Museum of History Associates designated for the Pharmacy Exhibit.

Mr. Smith introduced Milton Whaley, new co-chairman of the committee, who presided during the remainder of the meeting.

Milton appointed Vivia and Jimmy Creech, who are very interested and familiar with our committee as well as the Museum of History Associates, to prepare special resolution regarding Museum Project, to be presented at the 1990 NCPhA Convention. This resolution is to be given to Dave Work, Chairman of the Resolutions Committee of the NCPhA, by the middle of April 1990.

Roland Thomas of Charlotte was recognized for his excellent abilities in modernizing pharmacies and the trust that our committee has in him to de-modernize for our Museum Pharmacy.

John Ellington, Museum Administrator, showed a model of the building and architectural drawings, and brought us up to date on the new Museum of History and placement of the different exhibits and galleries. We were pleased to learn that the "big hole" which is now visible is for 650 underground parking spaces. A restaurant and outdoor gardens will be added attractions for the new building.

The Museum Pharmacy will be located on the ground level. The theme will be "N.C. the Land and the People" and the Pharmacy will be very instrumental in depicting the changes we have encountered. The area allocated for the Museum Pharmacy has two bays (28x28-height 26 ft.) making approximately 2,000 sq. ft. of space. It was also noted that the area would be an unfinished shell, with plumbing installed for the soda fountain. Pharmacy group will be responsible for floor, ceiling, fixtures, etc. Ceiling will be suspended at appropriate height. John stated that the projected completion date for the building was the Fall of 1991, with an official opening during the short session of the Legislature during the Summer of 1992. In all probability, the Pharmacy Exhibit will not be ready for the official opening, but an open storage area on the third floor, could possibly be used to display pharmacy artifacts at the time of the opening. He emphasized the 1925 era for the Pharmacy Exhibit as a good pivotal time to depict in the pharmacy.

Eva Williamson related her close ties to Pharmacy and her interest in our Pharmacy Exhibit. She explained her responsibilities in coordinating fund raising for the Mu-

Continued on next page

MUSEUM COMMITTEE

seum as Executive Director of the Museum of History Associates. She noted that, of the 4.2 million needed, almost 3.9 million has been raised. She expressed her appreciation for our efforts and her belief that the Pharmacy Exhibit would be one of the most interesting and enjoyable exhibits. Ben Browning, Eve's grandfather, who was a pharmacist and owner of Browning Drug Store in Littleton, was the oldest living pharmacist and oldest alumnus of Wake Forest College at the time of his death in 1980. Her family has pledged a considerable amount of money to the Museum Pharmacy with the proposal that the pharmacy be named for her grandfather. Eve distributed a list of fixtures and items available for the new Pharmacy Exhibit. She had many of these most interesting artifacts on display at the meeting. The family pledges to date amount to $36,500. Milton thanked Eve for this very generous proposal and stated that the committee would take the proposal under consideration.

Milton related that W.J. and Vivian Smith, Rheta and Milton Skolaut, Dot and Banks Kerr and Neta have been responsible for the Pharmacy Artifacts that have been inventoried and stored at the Kerr warehouse in Raleigh. Mr. Smith distributed lists of these items. We also have a list of special items being held by donors until needed.

Thanks were expressed to Banks for this safe storage and also for donation of the purchase price for a metal ceiling to go in the Pharmacy Exhibit. Banks generously offered a truck to pick up and store fixtures and displays until needed for the Museum.

Through contact made by Neta and Milton Whaley, we have a list of tobacco artifacts available from Duke Homestead State Historic Site. These items are being held by A.Dale Coats, Historic Site Manager until the new Museum is completed.

Discussion was held regarding amount needed in budget, complete list of fixtures, and artifacts needed to establish the 1925 era Pharmacy. Clea Baker suggested looking at the pharmacy in the Smithsonian in Washington, D.C. He also suggested a private appraiser with Warner Art Collection, North River, Tuscaloosa, Alabama, to assist in appraising artifacts donated. Jimmy Creech has picture in color of old drug store, showing spittoons, dropped ceiling fans, marble floor, etc.

Roland Thomas shared locations of fixtures that were a possibility, with all fixtures coming from same drug store. Lowell Drug Company, West of Charlotte, is being sold. Roland and Milton Whaley are familiar with this transaction. Jack Watts suggested that we make contact very soon regarding these fixtures. Pictures will be sent to John Ellington for approval. John will then contact W.J. Smith and Milton Whaley.

Milton thanked Eve Williamson and John Ellington for their interest and support given to our group.

The consensus of opinion for things we need to focus on now:

1. Consideration of offer from Browning Family.
2. Complete list of Pharmacy Artifacts (fixtures and inventory) needed to establish the 1925–era Pharmacy Exhibit.
3. Roland Thomas to draw plans for inside of Pharmacy, showing placement of needed fixtures, etc. and to contact Lowell Drug Company buyers regarding fixtures.
4. Prepare budget for amount of funds needed to complete the Pharmacy Exhibit.
5. W.J. and Vivian Smith, Rheta and Milton Skolaut were appointed to work with Eve and John in preparing Pharmacy Brochure for publicity and fund raising.

Milton thanked everyone for their work on this Pharmacy Exhibit, with special thanks to W.J. and Vivian Smith. He encouraged each of us to be on special assignment to secure needed artifacts to make our Pharmacy Exhibit a living history and one that we would be proud to have had a part in establishing.

Thanks to Ruby Creech for preparing the Committee Report

PHARMACY AND THE PURSUIT OF GOOD GOVERNMENT

by J. Mark White

Fifth-Year Pharmacy Student at the University of North Carolina at Chapel Hill

Over the course of the summer, I participated in the Glaxo\APhA Good Government Scholarship Program. What follows is a synopsis of my thoughts on pharmacy and its role in political affairs. I urge all pharmacists and other health professionals to take the opportunity to get involved in their respective organizations and steer health care into a bright tomorrow for all.

Search for Good Government

People have searched for 'good government' throughout the pages of history. From this never-ending search for good government has evolved what we in the United States know as democracy. In essence, our government is "of the people" and "for the people." Unfortunately, our government is not always "by the people." Legislators often enact bills with inadequate or even inaccurate input from an outspoken few, such as lobbyists and political action committees (PACs).

The reason for this lack of input from other sectors of society is not always apathy. Most people are in fact very concerned about one or more current legislative issues. Nowadays, it seems that everyone has an opinion about something. The problem is that, other than brooding over the nightly news or the day's headlines, they do nothing to influence the system.

Working Within the System

All too often, the reason for their inaction is ignorance of the intricacies of government and lack of knowledge on how to influence the system. Glaxo and the American Pharmaceutical Association publish an excellent guide on how to influence legislators. But even if people know how to influence the system, they cannot implement their plan of action effectively if they do not understand how the system works. Knowledge is, or at least should be, a primary ingredient in good government. Having acknowledged this fact, I herein seek to rectify the situation by describing the general operations of a typical Congressional staff.

Personal staffs of Representatives are confined to 18 permanent and 4 temporary staff members. Senators, on the other hand, are not limited by a set quota but rather by a budget which varies by state. Staffs are organized according to the politician's goals and preferences. Usually the staff is divided among three offices. A Congressman typically has an office in his district, (often in his own hometown), in the state capital, and Washington, DC. Both scheduling and letters are usually dealt with in the State or District office.

Mail Generates Action

When letters arrive, they are sorted by category and routed to the appropriate staff member. When a response is indicated, a constituent letter is thoughtfully and carefully composed to avoid any 'bad press'. Some House offices are now incorporating a tracking system to follow letters through the process, although doing so is often 'contraindicated' by the results of cost effectiveness analysis.

Mail dealing with substantive legislative issues is often responded to by 'splicing' together a personal-looking letter via a word processor. However, letters requiring a personal response are not ignored. They are categorized by subject and passed up the ladder until, at some level, a response is composed. Whether or not the response comes from the actual Member of Congress depends on the sensitivity of the letter and the role the Congressman chooses to play in constituent correspondence. Nonetheless, the Member is informed of any and all mail trends and is advised accordingly. In fact,

Continued on page 15

The Views We Get Make It Well Worth The Trip.

The 12 members of our Pharmacy Consultant Panel bring viewpoints from a wide variety of disciplines all around the country. And our summer meeting is a special time to get together—a time to share views, ideas and experiences with an outlook to future professional needs.

For three days every summer, the panel members come together to talk, to listen, to share their enthusiasm and their commitment to the pharmacy profession and its bright future. We share that commitment—and keeping in touch with them helps us keep in touch with you and your concerns. Working together gives us all a better view of the future—and how to make it brighter.

Upjohn

The 1989 Pharmacy Consultant Panel—Left to Right:

Henri R. Manasse, Jr.
Dean, College of Pharmacy
University of Illinois at Chicago
Chicago, Illinois

Thomas R. Temple
Executive Vice President
Iowa Pharmacists Association
Des Moines, Iowa

John H. Vandel
President
Vandel Drugs, Inc.
Torrington, Wyoming

Margaret M. Chrymko
Assistant Director
Clinical Pharmacy Services
& Research
Hamot Medical Center
Erie, Pennsylvania

John K. Middleton
President, Pharmacy Programs
United HealthCare Corporation
Minneapolis, Minnesota

Calvin H. Knowlton
Owner, Amherst Pharmacy, Inc.
Lumberton, New Jersey

C. Fred Toney
Sr. Vice President
Sales & Merchandising
McKesson Drug Company
San Francisco, California

Herman L. Lazarus
Director
Department of Pharmacy
University of Alabama
Hospitals & Clinic
Birmingham, Alabama

Nelson L. Showalter
President
Williamson's Pharmacy
Harrisonburg, Virginia

Thomas M. Ryan
Sr. Vice President
Pharmacy Operations
Consumer Value Stores
Woonsocket, Rhode Island

William A. Gouveia
Director of Pharmacy
New England Medical Center
Boston, Massachusetts

John J. Fegan (not pictured)
Vice President
Pharmacy Operations
Pay 'N Save Inc.
Seattle, Washington

GOOD GOVERNMENT, *contd.*

among all forms of communication, including lobbying, spontaneous letters from constituents are rated by Members of Congress as having the highest impact.

You too can have an impact on legislation. Take time to express your opinions in the form of a letter to your Representative and preserve pharmacy as a mainstay in the future of modern health care.

Personal visits from constituents also rank high (#6) in degree of impact. Make plans now to visit with Congressman David Price as he speaks to an assembly of pharmacy students December 4,1989 at 7:00 pm in Beard Hall on the campus of the University of North Carolina at Chapel Hill.

Editor's Note: Mark White was one of six national winners in the Glaxo Good Government Contest.

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OBITUARIES

WILLIAM LAWSON BRADY III

William L. (Bill) Bradley III, Lumberton, died Thursday, October 20, 1989 at Duke Medical Center after an extended illness. He was 38 years old. Brady was the co-owner of the Medicine Shoppe in Lumberton which he helped open in 1978. He was a native of Fairmont and a 1974 graduate of the UNC School of Pharmacy. He practiced in Virginia before going to Lumberton as a staff pharmacist at Southeastern General Hospital. Brady was a member of the North Carolina Academy of Pharmacy

JULIUS ALBERT SUTTLE JR.

Julius A. Suttle Jr.,Shelby, died Sunday, June 4, 1989, at Cleveland Memorial Hospital. Suttle was 76 years old. He was a native of Lincoln County and was the owner of Suttle's Pharmacy from 1952 until 1976. Suttle was a graduate of Mars Hill College and attended Wake Forest College.

HERMAN ELMORE BLAKE JR.

Herman E. Blake Jr. of Concord died Monday, May 22, 1989, at the age of 67. Blake was born in Talledega, Alabama, and graduated from the University of South Carolina School of Pharmacy in 1948. He served four years in the US army with the rank of Major. Blake was retired at the time of his death.

JOHN WILSON ALLEN

John W. Allen, Highland, died Wednesday, October 25, 1989 at the age of 74. A native of Matthews, Allen graduated from the UNC School of Pharmacy in 1939. He served in the US Marines, was employed as a representative of Schenley Laboratories and was a part owner of several Charlotte area pharmacies.

Rogers Makes a Point—Left to right: Betsy Mebane, Ralph Rogers and Lib Rogers.
Photo by Qualex-Colorcraft

Sponsors and Award Recipient—Left to right: Ralph Rogers, Betsy Millar, Greg Marks and Clinton Rogers.
Photo by Qualex-Colorcraft

GREG MARKS HONORED AT ROGERS AWARD DINNER

Gregory Alan Marks, a rising fifth year student from Rockingham, was recognized as the eleventh recipient of the Ralph P. Rogers Sr. Pharmacy Administration Award at a dinner held in his honor at the Carolina Inn in Chapel Hill Thursday night, September 21, 1989.

The award, provided by the sons and daughter of the late Ralph Peele Rogers Sr. of Durham, is given to a fourth year pharmacy student at the University of North Carolina School of Pharmacy for excellence in pharmacy administration and an expressed interest in community (retail) pharmacy. Ralph P. Rogers Sr. was the owner and pharmacist of Rogers Drug Store in Durham for fifty years and was a past president of the North Carolina Pharmaceutical Association, the Durham Drug Club and the North Carolina Rexall Drug Club. Ralph P. Rogers Jr., Durham, J. Clinton Rogers, Durham, and Elizabeth Rogers Millar, Winston Salem, are the sponsors of the award.

Program participants included Dean Tom S. Miya, Dr. Jan D. Hirsch who gave a recount of the accomplishments of Mr. Marks which led to his selection, Ralph P. Rogers Jr. and A.H. Mebane III, Executive Director, NCPhA, who served as Master of Ceremonies. Guests included the recipient's parents and faculty members from the UNC School of Pharmacy Pharmacy Administration Division, as well as the award sponsors.

Marks was selected to receive this award by the faculty of the Division of Pharmacy Practice and is the son of Mr. and Mrs. E. Lazelle Marks Jr. of Rockingham, owners of Medical Center Pharmacy.

Left to right: Ralph P. Rogers Jr. presents the award check to Greg Mark. *Photo by Qualex-Colorcraft*

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See brief summary on adjacent page.

Brief Summary
PROFESSIONAL USE INFORMATION

DITROPAN®
(oxybutynin chloride)
Tablets and Syrup

CONTRAINDICATIONS

DITROPAN® (oxybutynin chloride) is contraindicated in patients with increased intraocular pressure (ie, glaucoma) associated with angle closure, since anticholinergic drugs may aggravate this condition.

It is also contraindicated in partial or complete obstruction of the gastrointestinal tract, paralytic ileus, intestinal atony of the elderly or debilitated patient, megacolon, toxic megacolon complicating ulcerative colitis, severe colitis, and myasthenia gravis. It is contraindicated in patients with obstructive uropathy and in patients with unstable cardiovascular status in acute hemorrhage.

DITROPAN is contraindicated in patients who have demonstrated hypersensitivity to the product.

WARNINGS

DITROPAN® (oxybutynin chloride), when administered in the presence of high environmental temperature, can cause heat prostration (fever and heat stroke due to decreased sweating).

Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with DITROPAN would be inappropriate and possibly harmful.

DITROPAN may produce drowsiness or blurred vision. The patient should be cautioned regarding activities requiring mental alertness such as operating a motor vehicle or other machinery or performing hazardous work while taking this drug.

Alcohol or other sedative drugs may enhance the drowsiness caused by DITROPAN.

PRECAUTIONS

DITROPAN® (oxybutynin chloride) should be used with caution in the elderly and in all patients with autonomic neuropathy, hepatic or renal disease. DITROPAN may aggravate the symptoms of hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, hiatal hernia, tachycardia, hypertension, and prostatic hypertrophy. Administration of DITROPAN® (oxybutynin chloride) to patients with ulcerative colitis may suppress intestinal motility to the point of producing a paralytic ileus and precipitate or aggravate toxic megacolon, a serious complication of the disease.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY. A 24-month study in rats at dosages up to approximately 400 times the recommended human dosage showed no evidence of carcinogenicity.

DITROPAN showed no increase of mutagenic activity when tested in *Schizosaccharomyces pompholiciformis*, *Saccharomyces cerevisiae* and *Salmonella typhimurium* test systems. Reproduction studies in the hamster, rabbit, rat, and mouse have shown no definite evidence of impaired fertility.

PREGNANCY. Category B. Reproduction studies in the hamster, rabbit, rat, and mouse have shown no definite evidence of impaired fertility or harm to the animal fetus. The safety of DITROPAN administered to women who are or who may become pregnant has not been established. Therefore, DITROPAN should not be given to pregnant women unless, in the judgment of the physician, the probable clinical benefits outweigh the possible hazards.

NURSING MOTHERS. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when DITROPAN is administered to a nursing woman.

PEDIATRIC USE. The safety and efficacy of DITROPAN administration have been demonstrated for children 5 years of age and older. However, as there is insufficient clinical data for children under age 5, DITROPAN is not recommended for this age group.

ADVERSE REACTIONS

Following administration of DITROPAN® (oxybutynin chloride), the symptoms that can be associated with the use of other anticholinergic drugs may occur:

Cardiovascular:	Palpitations, tachycardia, vasodilatation.
Dermatologic:	Decreased sweating, rash.
Gastrointestinal/ Genitourinary:	Constipation, decreased gastrointestinal motility, dry mouth, nausea, urinary hesitance and retention.
Nervous System:	Asthenia, dizziness, drowsiness, hallucinations, insomnia, restlessness.
Ophthalmic:	Amblyopia, cycloplegia, decreased lacrimation, mydriasis.
Other:	Impotence, suppression of lactation.

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CREATIVITY IN WORKING GROUPS

This is the ninth in a series of articles for professionals who manage and managers who lead professionals, and those who are both. Pharmacists operate with one license, but fill many different roles in hospitals, chain stores, individually owned stores industry and educational settings. Along the way, they need a variety of management skills. These articles take a broad persective on management concepts we hope you will be comfortable using.

The preceding article emphasized the factors important to the creativity of individual professionals. Those factors of open and frequent communication with the outside, acceptance of the ideas of others, celebration and encouragement of risk-taking also apply to working groups. In addition managers must:

- Develop teams with both generalists and specialists
- Manage each team's composition over time
- Encourage groups in interact effectively
- Encourage groups to analyze their own behavior

Don't Overspecialize

High performing groups communicate frequently and effectively with each other and with other units of the firm, but over time they tend to lose steam. They age. My colleague, Dr. William Fischer, has suggested that they tend to become overspecialized with time and communicate less and less with their outside sources. At first they are very open to new ideas, but then with success they come to have confidence in their own abilities and expertise and effectively know more and more about less and less as they continue to focus on a narrow range of problems. The group must be leavened from time to time by new faces and by generalists to counterbalance that overspecialization.

CURTIS P. MCLAUGHLIN is Professor of Business Administration in the School of Business and Professor of Health Policy and Administration in the School of Public Health at the University of North Carolina at Chapel Hill. He received his masters and doctorate degrees in Business Administration from Harvard University Business School.

Managing the Team Composition

The battle against overspecialization is only one of the battles in keeping groups performing at a high level. Group leadership and group process must be maintained. The composition of the group must be maintained. The composition of the group must be planned and then followed. The process must be watched and fine-tuned. the reward system must be carefully designed, especially if the task is outside the unit's core activities.[2]

Most important work is done by teams. Our project studying the search for technical information for policy analysis in government and industry confirms this. Teams are formed as issues arise. Industry does a slightly better job in forming teams than government, because industry personnel do not care about departmental turf as much. Industry tends to assign the people to the team who are closest to the required infor-

mation and to pay less attention to having senior representation from each concerned group. Getting people who are close to the information is critical. Bosses are often not conversant with current practices. They know how it used to be done when they were at that level in the organization, but not how it is done now. Therefore, it is important to get everyone involved into a room and review the procedures.

Some years ago I was called in to study a situation in which patients were complaining about the long waits in an orthopedica outpatient clinic in a Boston hospital. It was an orthopedic referral clinic and all patients were given appointments scheduled on a computer. The first thing we did was to make sure the computer system was working correctly. Since it was, we put a volunteer in the clinic to record their arrival times, their visit times and their departure times to see how fast they were treated. Some took four-and-a-half hours to go through the process. That was unacceptable to clinic management, so we went on to the next step. I called into a meeting representatives of all the types of people employed in the clinic - aides, nurses, secretaries, residents, interns and staff attendings. We began by going through the procedure for processing patients. I asked who saw the patient first. The receptionist did. When the patients announced themselves, she would reach into a file drawer and pull out the patient's file, place it on the top of the stack of files on the corner of her desk and then tell the patient to have a seat. "Who sees the patient next?" "I do," said the aide. "When an examining room is open, I take a patient's file folder off the bottom of that stack and call the patient to go with me to the examining room." Immediately people around the table began to say "Uh oh!" They had already found one source of the problem. Can you figure it out?

The reservation system was being circumvented by a minor detail in its implementation. The way that the folders were being placed on the top of the pile and retrieved off the bottom led to a de facto first-come-first-served system. This was an inner city teaching hospital and the patients who lived around the hospital quickly caught on and came early to get out early. Patients referred from the suburbs believed their appointment times and came as scheduled. They were the ones that waited and, of course, they were the ones who complained and were heard.

There is no substitute for the people with the right, current information for solving problems. Management has to get the people on the firing line involved in decisions. Otherwise they will not have good enough information and may make themselves look foolish in the eyes of their own people.

Another role of the management is to encourage the free expression of ideas, making sure that minority viewpoints are listened to. Even the wildest ones often contain the kernel of highly creative ideas.

Another is to make sure that the group is linked to a gatekeeper. This is especially important for research groups. The gatekeeper, is not only a route in for important information, but also a route out for good ideas that are useful to others. Sometimes the gatekeeper is the group's manager, but that certainly is not frequent nor necessary. If, however, the group's manager is the primary gatekeeper and is transferred out, care must be given to make up for that major loss.

Encouraging Effective Interaction

Research on how successful firms keep ideas flowing suggests some steps to follow. Souder3 emphasizes having the appropriate organizational climate to stimulate ideas, encouraging the generation of concepts, assessing ideas for their fit to organizational needs, and gaining acceptance and commitment for good ideas. He suggests that professionals are often their own worst enemies in that regard, because they screen ideas too conservatively. An idea that is off the wall may still generate another idea that works. He suggests idea review teams that

Continued on next page

MANAGEMENT SERIES: GROUP CREATIVITY

screen ideas early and give rapid feedback, usually positive to the person or groups that put them forward. He suggests that the ideas be handled by a system designed to:

1. Build the confidence of the submitting employee in the firm.
2. Assure that credit for the idea goes to the originator.
3. Provide shelter for the idea from its likely enemies.
4. Assure the system is responsive to the originator or submitter.
5. Assure that the idea gets a fair hearing.
6. Make sure that the originators of good ideas are rewarded.

What counts is not so much the average quality of the ideas, but their quantity. Souder emphasizes that one key to success is the willingness of multidisciplinary groups to work together on embryonic concepts that match organizational needs and make something out of them.

Groups Studying Their Own Behavior

It would be nice if the groups were capable of studying their own behavior and learning how to improve it over time. Obviously, this can be taken to an extreme with the group engrossed in its own process rather than wrestling with practical problems. Yet it is important that management train group members to understand group processes will enough to be able to appoint one of their number to be a participant observer once in a while and report back what is happening. Are people stuck in familiar roles and not carrying their load? Are certain individuals dominant? Are some members playing games or becoming a broken record? Are we like a bad marriage and not even letting people finish sentences? Some reasonable process introspection and confrontation can help a group a lot, but this will not happen unless management sets a norm of acceptance and gives people the skills to do it.

[2]R.W. Zmud and C.P. McLaughlin, "That's Not My Job: Managing Secondary Tasks Effectively," Sloan Management Review, Winter 1989, pp. 29-37.

[3]W. Souder. "Stimulating and Managing Ideas." Research Management, May-June, 1987, pp. 13-17.

BIRTH ANNOUNCEMENTS

Frank and Jane Burton, Greensboro, announce the birth of their son, Bryan Lawrence, on September 3, 1989. Bryan weighed 7 pounds, 3 ounces. Frank is president-elect of the NCPhA.

Mr. and Mrs. *John L. Andrews III*, class of 1982, UNC, announce the birth of a son, Jadie Lee on September 14, 1989. He weighed 8 pounds 7 ounces. Mrs. Andrews is the former Jana Durham.

Sharon and Steve Perry of Dunn announce the birth of a son Paul Hatcher who arrived on April 14, 1989 weighing 9 pounds 3.5 ounces. Sharon is a 1982 graduate of the UNC School of Pharmacy.

Mike and Linda Woodard, Raleigh, are the proud parents of Brad Michael, born June 24, 1989. Mike is a 1977 graduate of the UNC School of Pharmacy. Grandparents are Mr. and Mrs. John Corey of Stokes and Mr. and Mrs. Barney Paul Woodard of Princeton.

CORRESPONDENCE COURSE: THE ROLE OF ASPIRIN IN PREVENTION OF CORONARY HEART DISEASE

BY

Thomas A. Gossell, R.Ph., Ph.D.
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Ohio Northern University
Ada, Ohio

and

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Goals

The goals of this lesson are to describe the action of low-dose aspirin on protecting against coronary heart disease.

Objectives

At the conclusion of this lesson, the participant will be able to:

1. choose the correct mechanism of action, adverse reactions and precautions, as reported for low-dose aspirin therapy;

2. demonstrate an understanding of the theoretical importance for administering the correct dose of aspirin;

3. choose the most appropriate aspirin formulation or product to recommend for a particular situation; and

4. convey appropriate advice when counseling consumers on aspirin use.

There is evidence that aspirin protects against myocardial infarction (MI) and sudden death in certain cardiovascular diseases. This is a claim that some studies substantiate, and manufacturers of OTC aspirin products intimate to be true. Aspirin is indicated for this use when prescribed by a physician. However, American consumers are undoubtedly self-medicating based upon advertisements and articles they have read in the popular press.

This article examines the data which led to FDA approval of the indication of aspirin for decreased morbidity and mortality associated with certain cardiovascular diseases. It also summarizes more recent information which suggests that men who do not have a history of previous cardiovascular disease may also benefit from this therapy.

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CE COURSE, ASPIRIN

This article discusses the limitations of aspirin prophylaxis, stresses the importance of taking the proper dose, and cites the improvement in protection that some studies have shown can be expected. It also provides specific information to convey when counseling consumers on the use of aspirin for this indication.

Background

The results of numerous clinical trials have clearly demonstrated that aspirin decreases the chance for morbidity and premature death from certain cardiovascular diseases. It is approved for physician-supervised use to lower the risk of non-fatal myocardial infarction or death, in patients with unstable angina, or who had a previous MI. Such use is designated secondary protection, since these patients all have a previous history of cardiovascular disease.

Aspirin is also indicated in low doses to reduce the risk of recurrent transient ischemic attacks in men. Although these indications are included in the professional labeling, FDA does not permit these claims to be advertised for unsupervised self-medication with OTC products. Nonetheless, with publication of the results of a large study that showed that the chance of MI was decreased with prophylactic aspirin use, advertising and articles in the popular press and other media appeared directly to the public, claiming the virtues of this wonder drug for this purpose.

Cardiovascular Disease

Cardiovascular disease is a major health threat with approximately 1.5 million Americans experiencing a heart attack each year. This includes both MI and sudden death from cardiovascular complications. More than 350,000 of these victims die before reaching an emergency facility. Another 200,000 die within the first 24 hours. Of the survivors, about 10 percent die within the next year. Two-thirds of these victims die within the first six months, usually from recurrent infarction or sudden cardiac death. Those who survive beyond the first year experience a death rate of 3 to 5 percent per year.

However, this death rate has been slowly but steadily declining in the U.S. in recent year. This is probably due to better therapeutic intervention and to a general trend of Americans taking better care of themselves.

Thromboembolic occlusions in the coronary arteries are the major cause of morbidity and mortality in Americans. Blood clots inside of blood vessels are referred to as thrombi. When a thrombus breaks away and moves elsewhere, it is called an embolus. Emboli that lodge in and occlude coronary blood vessels result in MI and tissue death. Platelet plugs comprise most of the bulk of arterial thrombi. Platelet aggregation may also contribute to atherosclerosis development. An appropriate program to reduce morbidity and mortality, therefore, is to decrease the overall tendency of platelets to adhere to each other, or to blood vessels walls. This is the proposed mechanism of aspirin's prophylaxis potential.

Aspirin as Secondary Prophylaxis for Coronary Heart Disease.

Antithrombotic agents suppress platelet activity. They are employed primarily to treat arterial thrombotic pathology. In contrast, **anticoagulant drugs** such as heparin and warfarin reduce the synthesis or activity of clotting factors. These actions are directed toward venous thrombotic disorders.

Aspirin has been suspected to have therapeutic value to individuals with coronary heart disease for more than 30 years. Two large clinical trials demonstrated its efficacy in patients with unstable angina. In one investigation, 31 of 625 (5 percent) of men who took a single 325 mg aspirin tablet each day for 12 weeks suffered an acute MI or died, versus an incidence of 65 of 641 (10 percent) of men who took a placebo. In the other study, men and women took either 325 mg aspirin four times/day for a mean

Table 1

Representative OTC Aspirin Products

Product (Mfr)	Dosage Form	Strength
Alka-Seltzer (Miles Labs)	Tablet, effervescent	324 mg
Arthritis Pain Formula (Whitehall)	Tablet, buffered	486 mg
A.S.A. (Lilly)	Suppository	324mg, 684 mg
A.S.A. Enseals (Lilly)	Tablet, enteric coated	325mg, 650 mg
Ascriptin (Rorer)	Tablet, buffered	325 mg
Ascriptin A.D. (Rorer)	Tablet, buffered	325 mg
Ascription Extra Strength (Rorer)	Tablet, buffered	500 mg
Aspergum (Plough)	Gum tablets	227.5 mg
Asperbuf (Bowman)	Tablet, buffered	325 mg
Bayer (Glenbrook)	Tablet	325 mg
Bayer Children's (Glenbrook)	Tablet, chewable	81 mg
Buffaprin (Buffington)	Tablet, buffered	324 mg
Bufferin (Bristol-Myers)	Tablet, buffered	324 mg
Bufferin, Arthritis Strength (Bristol Myers)	Tablet, buffered	486 mg
Bufferin, Extra Strength (Bristol-Myers)	Tablet, buffered	500 mg
Buffex (Mallard)	Tablet, buffered	325 mg
Buffinol (Otis Clapp)	Tablet, buffered	324 mg
Cama Arthritis Strength	Tablet, buffered	500 mg
Ecotrin (SmithKline)	Tablet, enteric coated	325 mg
Ecotrin Maximum Strength (SmithKline)	Tablet, enteric coated	500 mg
8-Hour Bayer (Glenbrook)	Tablet, (time release)	650 mg
Empirin (Burroughs Wellcome)	Tablet	325 mg
Encaprin (Vicks Health Care)	Capsules, enteric coated, granules	325mg, 500 mg
Magnaprin (Rugby)	Tablet, buffered	325 mg
Magnaprin, Arthritis Strength (Rugby)	Tablet, buffered	325 mg
Maprin (Quantum)	Tablet, buffered	325 mg
Maprin I-B (Quantum)	Tablet, buffered	325 mg
Maximum Bayer Aspirin (Glenbrook)	Tablet	500 mg
Measurin (Winthrop-Breon)	Tablet, timed release	650 mg
Norwich Aspirin (Proctor & Gamble)	Tablet	325 mg
St. Joseph Children's Aspirin (Plough)	Tablet, chewable	81 mg
Wesprin Buffered (Wesley)	Tablet, buffered	325 mg

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GEER

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CE COURSE, ASPIRIN

duration of 18 months, or placebo. Seventeen of 176 (6.1 percent) of patients taking aspirin experienced an MI or died, compared to 36 of 179 (12.9 percent) of patients taking placebo. Both of these studies illustrated there was a 50 percent reduction in the risk for infarction and/or death in the aspirin-treated groups.

Another six studies were undertaken to assess aspirin's activity in post-MI patients. More than 10,800 predominantly male patients were involved. Aspirin was taken in doses ranging from 300 to 1500 mg/day, beginning three days to more than five years after the onset of their acute MI. Studies continued for intervals ranging from less than one to more than four years.

The pooled data revealed that there was an approximate 21 percent overall reduction for total or nonfatal reinfarction, and 16 percent overall risk reduction for cardiovascular death.

Aspirin as Primary Prophylaxis for Coronary Heart Disease

To evaluate whether aspirin conveys primary protection, i.e., protects men who have never had an MI, 22,000 male U.S. physicians entered a clinical trial. Ages ranged from 40 to 84 years. Half of them received 325 mg buffered aspirin every other day, the others a placebo. After nearly five years of follow-up, the total number of myocardial infarctions among the physicians on aspirin was reduced 47 percent.

The incidence of hemorrhagic stroke was increased slightly, but the increase was not significant. Overall, aspirin did not affect the total number of vascular deaths or deaths from all causes. And when persons with nonfatal MI, nonfatal strokes, and vascular deaths from all causes were combined, the group receiving aspirin still had a 23 percent reduction in risk.

Another study involving approximately 500 British physicians showed that 500 mg aspirin/day did not significantly reduce the incidence of MI. The smaller size of the group and higher dose may account for the conflicting data.

Pharmacology of Antithrombotic Activity

Aspirin is believed to convey antithrombotic activity by inhibiting the enzyme cyclo-oxygenase in platelet membranes (Figure 1). This enzyme is responsible for converting arachidonic acid in the platelet membrane to the prostaglandin, thromboxane (TXA_2), a potent stimulant of platelet aggregation and vasoconstriction.

A similar inhibitory reaction occurs in the endothelial cells of vascular tissue. There, cyclo-oxygenase is responsible to catalyzing formation of a different prostaglandin, prostacyclin (PGI_2). This is a potent inhibitor of platelet aggregation, and causes vasodilation. Of major importance is that inhibition of cyclo-oxygenase in platelets is irreversible; inhibition in vascular endothelium is reversible.

It is argued that aspirin could have a thrombogenic effect (i.e., stimulate thrombus formation) since aspirin blocks the production of PGI_2. This secondary reduction in PGI2 levels could actually be detrimental to patients with thrombi, or to other high risk patients who were predisposed to them. A thrombogenic effect from aspirin has indeed been demonstrated in animals. Extremely high doses (e.g., 200 mg/kg or more) are required to initiate thrombosis. In clinical studies of patients with rheumatoid arthritis or similar disorders who are treated with aspirin doses in excess of 3 gm/day, the drug has not shown such increased activity for thrombus formation. Individuals with congenital cyclo-oxygenase deficiency who are unable to synthesize both TXA2 and PGI2 also do not experience thrombotic episodes, and in fact, they actually have a mild tendency toward hemorrhage. From these and similar observations, it can be concluded that large doses of aspirin do not promote thrombogenic activity.

Its lack of thrombogenic action is partly related to characteristics of the platelets and endothelial cells. Platelets do not contain a

Continued on next page

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nucleus and are unable to synthesize significant amounts of protein (enzyme). Once the enzyme is inhibited, antithrombotic activity is maintained for the life of the platelet, approximately 8.2 days. However, arterial vessel wall endothelial cells contain nuclei and synthesize new enzyme on demand. These cells completely recover from aspirin action in approximately 35 hours.

Other mechanisms may also contribute to aspirin's beneficial effects. For example, a mechanism that is unrelated to platelet cyclooxygenase inhibition has been demonstrated in uremic patients.

Most authorities agree that aspirin dosage must be regulated. This contrasts with evidence presented earlier that showed selective inhibition of TXA2 synthesis, without appreciable effect on PGI2 formation. The situation is compounded further because, within four hours following a low oral dose of aspirin, sufficient new platelets are formed and added to the circulation to initiate full platelet aggregation in response to precipitating factors. It only take 10 percent of nonacetylated platelets of the total, to restore the blood's potential for full aggregation activity.

Antithrombotic doses of aspirin are reported to be 100 to 1000 mg/day, even though doses of 325 mg/day inhibit PGI2 formation. Low doses of 40 to 60 mg/day selectively inhibit TXA2, but not PGI2 production. Limited studies have shown that 40 mg every 48 hours may have the maximum antithrombotic effect.

Because of its short half-life (2 to 3 hours), doses such as 20 mg every 4 to 6 hours (i.e., quartered pediatric aspirin tablets) may provide more effective drug action than a single 325 mg dose taken once a day. Investigation to confirm or deny the validity of these regimens has not been undertaken to date.

Aspirin Formulations and Derivatives

The only form of salicylate that confers antithrombotic protection is aspirin. Non-acetylated derivatives of salicylic acid such as sodium salicylate, or magnesium- or choline salicylate, are not effective. Other nonsteroidal anti-inflammatory agents have not been evaluated.

Most studies have employed plain or buffered aspirin tablets. Similar cardioprotective property can be shown with enteric coated tablets, capsules and buffered aspirin in solution. However, one tablet of buffered aspirin in solution contains 24 mEq sodium which may not be suitable for persons with active sodium retaining states such as renal failure or congestive heart

Adverse Effects

Adverse effects of aspirin are dose-related, and restricted mainly to the gastrointestinal tract. Nausea, heartburn, stomach pain and constipation are common. A single dose of 325 mg of aspirin can cause measurable gastrointestinal bleeding.

Since all of these adverse effects relate to the presence of gastric acid, they can be minimized by neutralizing gastric contents with antacids, or reducing acid release with H2-antagonists. Also, gastric distress can be minimized by taking enteric coated products. Buffered aspirin tablets contain insufficient alkalinizer to reduce acid secretion or protect against drug-induced mucosal erosion. They are no more effective in alleviating adverse gastric reactions associated with acid release, than nonbuffered aspirin tablets.

The risk of developing a gastric ulcer from taking aspirin have been shown to be dose-related; ulceration is unlikely if fewer than 15 tablets are taken per week. Moreover, persons with duodenal or gastric peptic ulcers heal while continuing to take prophylactic aspirin therapy. It is nevertheless prudent for persons with a history of peptic ulcer disease to restrict aspirin therapy or to use an enteric coated dosage form.

Individuals may occasionally experience respiratory and/or dermal symptoms characteristic of aspirin sensitivity. Such may occur within minutes, or several hours of a

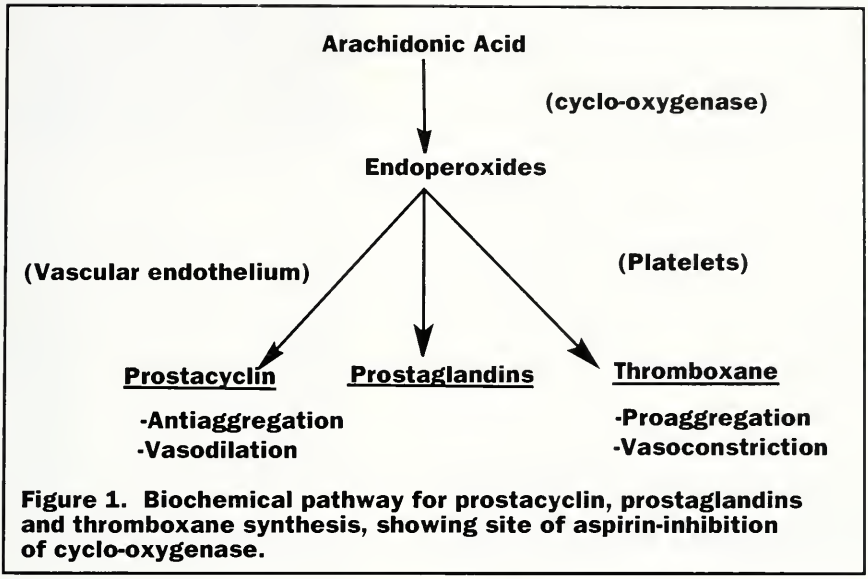

Figure 1. Biochemical pathway for prostacyclin, prostaglandins and thromboxane synthesis, showing site of aspirin-inhibition of cyclo-oxygenase.

dose. The extent of allergy to aspirin is estimated to be less than 0.3 percent for the general population, and greater than 50 percent for patients with asthma, nasal polyps or severe atopy (a clinical hypersensitivity state that is influenced by heredity).

The extent of adverse reactions to 1000 mg aspirin/day was determined in a study of 4,500 people. The percentage incidence of unwanted response to aspirin and placebo, respectively, was: stomach pain (14.5 percent, 4.8 percent), heartburn (11.9 percent, 4.8 percent), and hospitalization for gastrointestinal disorders (4.9 percent, 3.5 percent). A slightly increased systolic pressure of 1.5 to 2.1 mm Hg, and diastolic pressure of 0.5 to 0.6 mm Hg was noted.

Counseling Consumers

Annual aspirin usage in the United States is reported to be as high as 20 thousand tons. Consumers may not place high confidence in its ability to reduce morbidity and mortality from heart disease since it is such a commonly used drug. But, because of potential benefit from low doses, its OTC availability and relative lack of side effects in antithrombotic doses, as well as its low cost, the use of aspirin prophylaxis to reduce the risk of myocardial infarction or recurrent transient ischemic attacks in men may make sense - as long as it is physician-supervised.

Most individuals involved in clinical trials have been males. It can be assumed that similar use in women is appropriate. The official product labeling does not discourage women from using aspirin; it notes only that there is a lack of available information to confirm efficacy.

A common question about aspirin use to reduce the incidence of coronary heart disease is, "Who will benefit?" The data are still not clear as to long-term ramifications. Any person who asks whether he might benefit from prophylactic aspirin dosing should be advised to discuss this with a physician. Therapy should proceed only under a physician's guidance. Pharmacists should inform consumers that self-therapy is not in their best interest.

Consumers should be told to take each dose with a glassful of water or milk, or a light snack. They should keep the bottle tightly closed between uses, and away from direct heat or moisture.

Patients should also remind their physician and dentist that they are taking aspirin before receiving any other treatment or taking any other drug. And they should

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discontinue therapy one week before undergoing surgery, unless their physician advises otherwise.

Persons who are at high risk of cardiovascular disease should follow their physician's recommendations to reduce the risk. Eighty to 90 percent of all cardiovascular disease inthe U.S. is attributed to modifiable risk factors of hyperlipidemia, hypertension, obesity and smoking. Cigarette smoking is said to be the single most preventable cause of cardiovascular and noncardiovascular morbidity and mortality in the U.S. Altering these factors improves the prognosis that cardiovascular disease will be lessened.

NEW MEMBERS

Welcome to these new members who have joined NCPhA since the last listing. The total of new members for 1989 is now 281. Our goal of 300 is within reach.

Ken Krause, Gastonia
Susan Moss Krause, Gastonia
Jonathan Miller, Fayetteville
Richard W. Raspet, Greensboro
David C. Burroughs, Charlotte
Tracey M. Collins, Cary
Jeanne M. Bertch, Durham
Ron Forrester, Matthews
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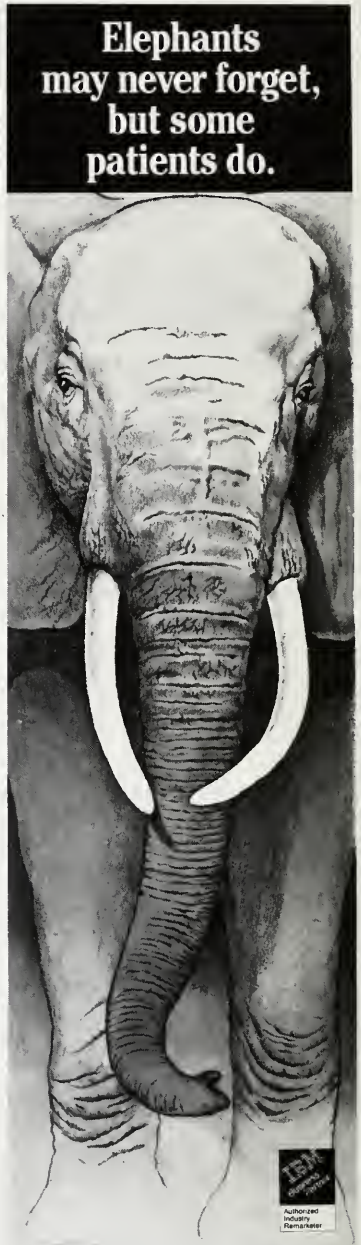

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CORRESPONDENCE COURSE QUIZ

Aspirin in Coronary Heart Disease

1. Which of the following is considered to be the single most preventable cause of cardiovascular morbidity in the U.S.?
   a. Cigarette smoking
   b. Hyperlipidemia
   c. Hypertension
   d. Obesity

2. Antithrombic agents are employed primarily to treat:
   a. arterial thrombic disorders.
   b. venous thrombic disorders.

3. The major cause of occlusion in the coronary arteries is:
   a. ventricular fibrillation resulting from A/V nodal block.
   b. excessive ischemia due to severe anginal attacks.
   c. vascular spasms after overstimulation by the vasomotor center.
   d. thrombi that embolize and lodge in coronary blood vessels.

4. All of the following are appropriate points of information for counseling consumers on the use of aspirin to reduce the risk of myocardial infarction EXCEPT:
   a. "Each dose should be taken with a glass of fluid or a light snack."
   b. "Check with your doctor before deciding to begin this use."
   c. "All forms of salicylate derivatives are equally effective."
   d. "Keep the bottle tightly closed to protect the tablets from deterioration."

5. Which of the following represents the estimated number of Americans who experience heart attacks each year?
   a. 750,000
   b. 1,500,000
   c. 2,500,000
   d. 5,000,000

6. Aspirin is believed to convey its antithrombotic activity by inhibiting the enzyme:
   a. cyclo-oxygenase.
   b. monoamine oxidase.
   c. prostacyclinase.
   d. thromboxenase.

7. The chemical that is the substrate of the enzyme described in questions #6 above, and which is metabolized to prostaglandins is:
   a. arachidonic acid.
   b. lactic acid.
   c. prostaglandic acid.
   d. uric acid.

8. All of the following statements are true EXCEPT:
   a. aspirin is approved for physician-supervised use to lower the risk of myocardial infarction.
   b. aspirin is indicated for prescribed use to reduce the risk of recurrent transient ischemic attacks in men.
   c. aspirin decreases the chance for morbidity and premature death from certain cardiovascular diseases.
   d. aspirin is indicated for self-therapy in decreasing the risk of death in persons with previous myocardial infarction.

9. The substance that is a potent stimulator of platelet aggregation and causes vasoconstriction is:
   a. prostacyclin.
   b. thromboxane.

10. Anticoagulant drugs are employed primarily to treat:
   a. arterial thrombic disorders.
   b. venous thrombic disorders.

Answer sheet is on page 36

WOMAN'S AUXILIARY FALL CONVOCATION

The Woman's Auxiliary held its Fall Convocation at the Institute of Pharmacy in Chapel Hill October 5th. It was an informative and fun-filled day. The program began at 9:30 a.m. with registration and a coffee hour hosted by our State Hospitality Committee, Mary Lou Worley, Chairman; Daphne Ashworth, Margaret Boyd, Mary Good, Maud McCombs, Suzan Maddox, Lynn Taylor and Anne Woodard. Daphne Ashworth welcomed everyone and Sybil Skakle gave an inspiring invocation. Suzan Maddox had the Roll Call of the auxiliaries and approximately fifty five members and guests attended. Our special guests were introduced by A. H. Mebane III, Executive Director of the NCPhA: Dean Tom S. Miya, UNC School of Pharmacy; Dean Ronald W. Maddox, Campbell University School of Pharmacy; Ralph H. Ashworth, President, NCPhA and Rudy Snow, President, TMA , all of whom brought us Greetings.

The Vial of Life Report was given by Jerry White, Chairman and this program is still going very well. Jewell Oxendine reported on Mission Air. They are still in great need and the Auxiliary contributed $500.00 to this program at our first board meeting in July. Lib Fearing, Co-Chairman of the Campbell University Pharmacy School Student Scholarship Fund Committee, read a solicitation letter that will be sent to various people who are interested in Campbell's School of Pharmacy. The Executive Board voted to give $3,000.00 to establish the Scholarship Fund at our July meeting. We hope to raise at least $15,000.00 by next spring in order to give a scholarship from the interest generated. Each of the committee members pledged $100.00.

The Ways and Means Report was given by Chairman Dianne Moody. She is really working hard! The Auxiliary will have a

The "Prime Time Pharmacy" players at the Church Street Pharmacy.
Photo by Qualex- Colorcraft

FALL CONVOCATION

raffle for ten prizes and the $1.00 raffle tickets for you to purchase will be mailed to auxiliary members at the beginning of the year. Winning tickets will be drawn at the Convention. Dianne has already gotten our first prize of $700.00 cash! There will be other exciting prizes, so watch for your raffle tickets in early 1990! Our Membership Report was given by Frances Jones. We need you so don't forget to send in your dues!

My theme this year is "Working to Combat Illiteracy". Vivia Creech introduced our first guest speaker, Nancye Gaj, Raleigh, President of MOTHEREAD, INC. She is a reading specialist and adult educator and has worked in all aspects of literacy education for the past 16 years. She and four of our auxiliary members, Jerry White, Mary Good, Ginger Lockamy and Ruby Creech - our "Prime Time Pharmacy Players" gave an interesting skit about illiterate people buying their medicine and trying to remember directions in giving the medicine. Ms. Gaj then discussed ways how to help in these situations and how we can spot these people who cannot read. I hope you will get involved in your hometown literacy programs.

Al Mebane introduced our next guest speaker, David R. Work, Executive Director of the N. C. Board of Pharmacy who gave a very interesting talk on "Examples of Illiteracy in North Carolina". Mr. Work has been instrumental in the development of graphics (pictograms) on prescription labels in collaboration with The United States Pharmacopeial Convention, Inc.

Ginger Lockamy, Chairman of the Illiteracy Committee reported on our progress with our project - posters (pictograms) in every drug store window in NC to inform the people with reading difficulties that the pharmacist will help them. This committee has been hard at work and we hope to have more information about this by the first of the year.

Betsy Mebane, President
WOMAN'S AUXILIARY, NCPHA

Our lunch was catered by "The Catering Company" of Chapel Hill. In keeping with the theme, Daphne Ashworth provided beautiful and unique decorations of flowers and books for the tables. We were pleased to have four of our scholarship recipients present - Alan Clark, Brian Fulcher, Chris Stotka and Shelley Myott.

I was very happy and proud to introduce our musical entertainment, Alex Mebane of Nashville, Tennessee who sang his own compositions and accompanied himself on the keyboard. Alex writes, produces and acts in television commercials. Fun was had by all! It was a great day!

Betsy Mebane, President

URINARY INCONTINENCE: THE "CLOSET CONDITION" CAN BE CONQUERED

Think of the most embarrassing thing that can possibly happen to someone. Chances are, a bladder control accident in public would rank near the top of any list. While this is not surprising, the fact that 10 million Americans[1] have bladder control problems that may put them in such a situation is astonishing.

The clinical term for loss of bladder control is urinary incontinence. Contrary to widely held beliefs, it is neither a disease nor a normal consequence of aging.[2] Urinary incontinence is a symptom of an underlying condition. As such, incontinence may be managed and often cured.

Incontinence affects men and women of all ages, but is clearly more common among senior citizens. One study from the University of Michigan, Ann Arbor, estimates that as many as 30 percent of persons over the age of 60 experience some form of urinary incontinence.[3] Statistics from the National Institutes of Health 1988 Consensus Conference on Urinary Incontinence indicate that 15 to 30 percent of seniors living in the community and 50 percent of those in nursing homes suffer from the problem. In an age where talk of AIDS, condom use and psychological disorders is commonplace, it is time to bring bladder control problems "out of the closet."

Urinary incontinence has many causes and may take persistent physician evaluation. Conditions that can cause partial or total leakage of urine include: urinary tract infections, medication side effects, neurological disorders, bladder tumors, enlarged prostate, weakened pelvic floor muscles (usually related to childbirth), pelvic surgery and other physical factors, and even restricted access to toilets.

Treatment options are nearly as numerous as causes, a hopeful signal for sufferers. Another positive note — not all treatments involve surgery. Drug therapy, "Kegel" exercises to strengthen pelvic floor muscles, biofeedback, external collection devices, prostate and bladder surgery, artificial implants and absorbent products may individually, or in combination, help or cure urinary incontinence.[4]

To determine the most appropriate treatment(s), doctors first evaluate the type of incontinence present. Since fear and embarrassment keep 50 percent of all sufferers from consulting a physician,[5] evaluation itself can be a major hurdle! **Urge incontinence** is characterized by a sudden urge to urinate, followed by voiding before a person can reach the toilet. Drug therapy often is very effective for urge incontinence because medication can control bladder spasms or aid in constricting the bladder outlet.[6]

Stress incontinence describes loss of urine when coughing, laughing or doing any activity that increases abdominal pressure on the bladder. Women are most commonly affected, due to multiple childbirths or loss of hormones at menopause. Kegel exercises, some medications and several types of surgery may correct stress incontinence.

Overflow incontinence generally affects older men and is caused by an enlarged prostate, which obstructs the flow of urine out of the bladder. The bladder never empties completely, instead dripping "like a leaky faucet."[7] Prostate surgery and balloon dilators are treatments of choice.

Total incontinence indicates complete loss of control, often due to spinal cord injuries. Many nursing home residents are thought to be totally incontinent, when in fact this "functional incontinence" is due to an inability to reach facilities or remember proper toileting habits. Consultant pharmacists and medical directors may be able to reduce this problem by recommending strict toileting schedules. These may require extra

URINARY INCONTINENCE: CONTD.

personnel time, but actually can reduce costs of absorbent products and linen change time, along with odor problems. Certain medications also may help increase the interval between scheduled toilet visits.

As a urologist, I see many cases of incontinence, but, as the previous statistics prove, millions of sufferers do not consult a physician. Pharmacists, on the other hand, are important members of the medical team who also can help the incontinent find relief. Consumers hold such high regard for pharmacists that they may confide in a pharmacist before a physician, family or friends. The pharmacist can recommend seeking medical treatment, especially for those who may purchase absorbent products to hide the problem. While these products have their place, experts say they should be used "...temporarily to keep yourself from being socially embarrassed while your doctor evaluates and treats you."[8] Pharmacists also can recognize medications that may impair bladder control (chart 1) and alert patients to this possibility. If a bladder control problem is acknowledged by the patient, a check of current medications may reveal a simple solution. Besides recommending physician evaluation, pharmacists can suggest contacting nonprofit self-help groups for support and comfort (chart 2).

The pharmacist's opportunity is truly a quality-of-life issue. Incontinence itself is not life threatening, but can certainly ruin lives. For caregivers of senior relatives, confusion and anger over the problem can be devastating. For seniors, admission of the disorder may bring fear of losing independence and eliminating social activities. And with the over-65 group the fastest growing segment of our population, bladder control problems are bound to increase dramatically. But medical evidence shows there's hope, and numerous treatments are available. Patients must be encouraged to admit the condition and seek proper diagnosis. Pharmacists can help facilitate that process, providing support and encouragement for sufferers and family members, dispensing products with special care to the elderly and identifying longterm care residents who indeed may be treatable. Addressing the taboo topic of urinary incontinence is difficult for all medical professionals, but with courage and concern, pharmacists can help patients regain control of their lives.

Hector Henry, II, M.D. is a practicing urologist on the staffs of Cabarrus Memorial Hospital in Concord and University Memorial Hospital in Charlotte. He is associate consultant professor of urology at Duke University Medical Center and a member of the North Carolina Board of Medical Examiners.

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3. Diokno, Ananias C., M.D., and Iles, Robert L.: *Urinary Incontinence, The Hidden Handicap*, 1986; 9

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5. National Institutes of Health: *Consensus Conference Statement on Urinary Incontinence in Adults*, 1988; 5

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7. Pooser, Claire: "Incontinence Isn't Hopeless, Expert Stresses," *The Charleston Evening Post*, 16 May 1989; 1-A

8. Ibid., 3-A

Continued on next page

URINARY INCONTINENCE: CONTD.

Chart 1.
Medications Which Can ImpairBladder Control

Psychotropic agents
- Chlorpromazine
- Thioridazine
- Haloperidol
- Lithium

Alpha-blocking agents
- Prazosin
- Phenoxybenzamine

Diuretics
- Furosemide
- Bumetanide

Others
- Bromocriptine
- Metoclopramide
- Clonazepam
- Reserpine
- Methyldopa
- Phenytoin

Chart 2.

Self-Help Groups

Help for Incontinent People (H.I.P.)
P.O. Box 544-P
Union, SC 29379

The Simon Foundation
P.O. Box 835
Wilmette, IL 60091
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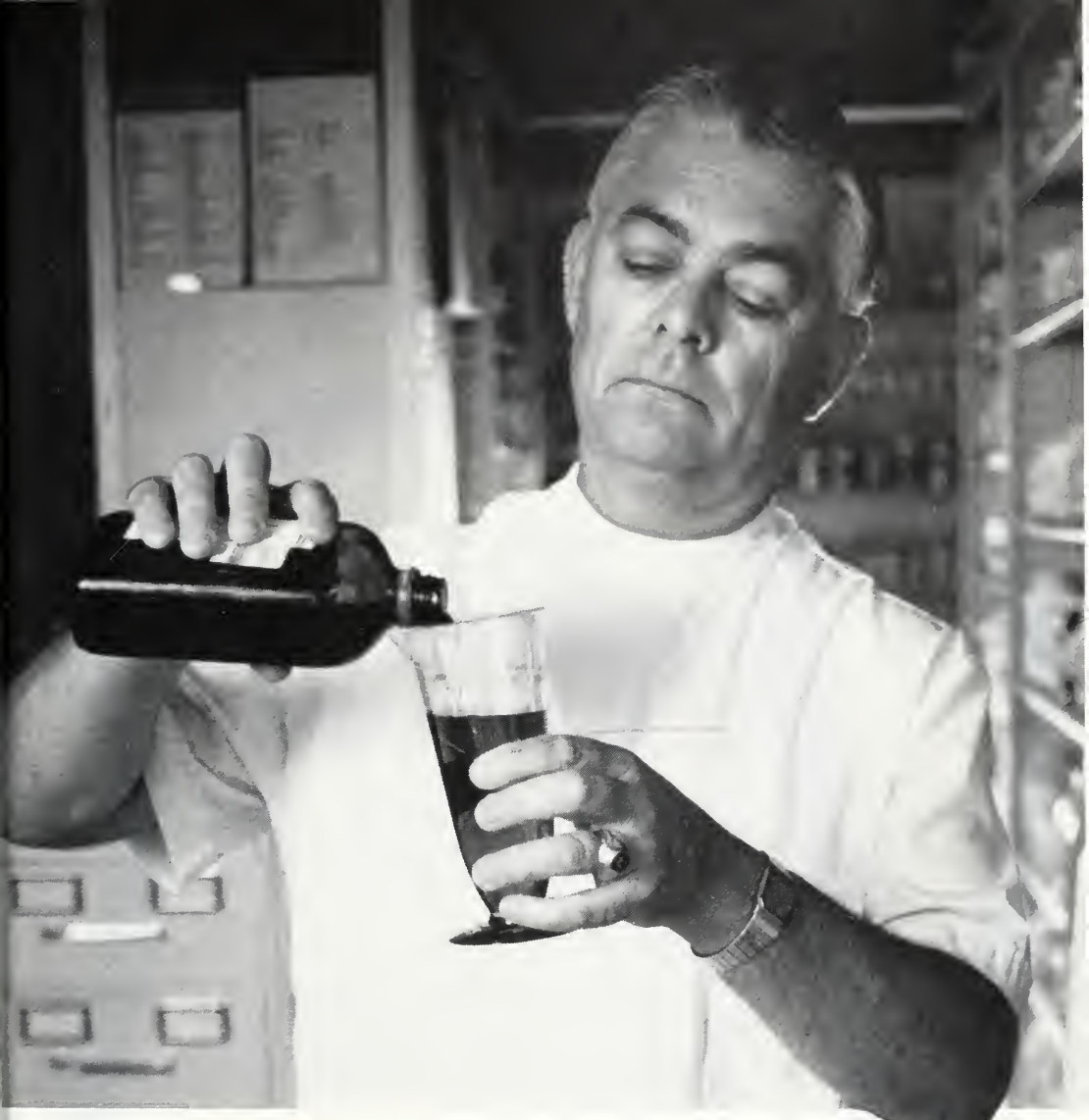

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